NEW YORK STATE | Department of Health | Office of Health Insurance Programs

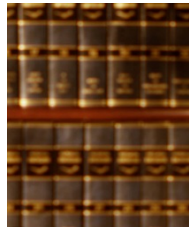
Guide to Timely Billing

Office of Health Insurance Programs (OHIP)

Division of OHIP Operations and Systems

August 9, 2018

- Introduction
- Regulations
- Adjustments versus Voids
- Acceptable Delay Reasons
- Timeliness Edits
- Resources
- Questions



NYS Regulation-Billing for Medical Assistance

Title 18, Section 540.6(a)- enforced since March 1978

90 days - Claims for payment of medical care, services, or supplies to eligible beneficiaries must be **initially** submitted within 90 days of the date of service.

60 days - Claims with errors or requiring documentation must be **corrected/resubmitted** within 60 days of notification.

30 days - Claims outside the control of the provider must be submitted within 30 days of coming within their control.

2 years- Claims must be **finally** submitted within 2 years.

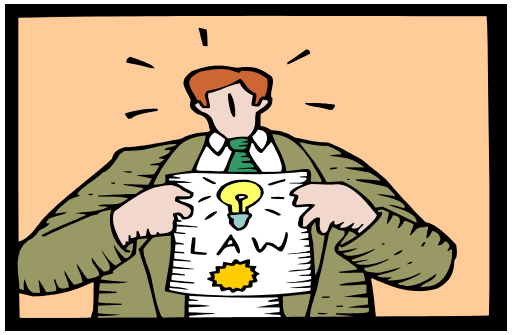
Regulatory Authority: 18 NYCRR 540.6(a)(1)

Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider.

Regulatory Basis: 18 NYCRR 635.1(a)

Reimbursement for services provided to recipients of MA shall be claimed on schedules and formats prescribed by the department and in accordance with instructions of the department.

Statutory authority: Social Services Law, 20, 34, 363-a, 364, 365-a, 367-b, 368-a, 368-b



Providers attest to true and accurate claims by signing the "Certification for Provider Billing" attestation upon Enrollment

Adjustments versus Voids
Definitions

- **Adjustments (referred to as "Replacement" on ePACES)**
  - cause the correction of information on the claim history records
  - cancels the original claim payment
  - adjusts the payment by re-pricing of claim based on the adjusted information

- **Voids**
  - cause the claim to be canceled
  - any resubmitted claim for the same services is considered a new claim submission

Adjustments versus Voids
How do I…?

- **Adjustments**
  - Must be submitted in a new claim form and all applicable fields completed
  - Adjustment field needs to be marked
  - The TCN# of the claim you are adjusting needs to be referenced.
  - Only previously paid claims can be adjusted
  - **Provider ID number** or the **Member's Medicaid ID number cannot** be adjusted.

- **Voids**
  - Must be submitted in a new claim form and all applicable fields completed
  - Void field needs to be marked
  - The TCN# of the claim you are voiding needs to be referenced.
  - Only previously paid claims can be voided
  - Results in the cancellation of the original claim history records and payment

Adjustments versus Voids
Why to Adjust rather than Void

- To correct a paid claim amount you should always do an Adjustment
- Adjustments do not cancel a claim and keeps the claim and edit history intact
- Adjustments should be submitted within 60 days of the date of **notification**

Adjustments versus Voids
Reasons not to Void

- Resubmitting a claim after a previously voided claim causes system processing to treat it as a **first time new** claim
- All timely submission edits apply
- All other edits will be reapplied to claim
- Subjected to the criteria for the two year submission rules for claims and will not qualify for a waiver if over two years old

HIPAA Delay Reasons and Codes

1 Proof of Eligibility Unknown or Unavailable
2 Litigation
3 Authorization Delays
4 Delay in Certifying Provider
5 Delay in Supplying Billing Forms
6 Delay in Delivery of Custom-made Appliances – **not accepted by NYS.**
7 Third Party Processing Delay
8 Delay in Eligibility Determination
9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10 Administrative Delay in the Prior Approval Process
11 Other
15 Natural Disaster

1. Proof of Eligibility Unknown or Unavailable

- Beneficiary's eligibility status is unknown or unavailable on date of service due to the beneficiary not informing provider of eligibility.
- Claim must be submitted within 30 days from the date of notification of eligibility.
- Not applicable to adjusted claims.

Examples of appropriate use of Delay Reason Code 1

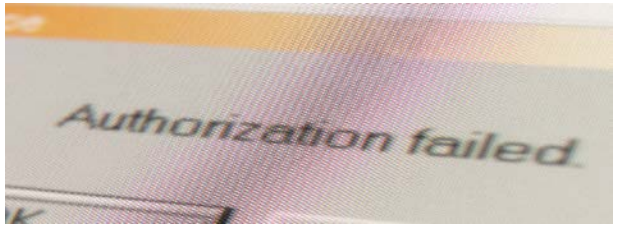
- A person comes into your facility for the first time saying they have no insurance and you provide medical services. Upon billing the person you discover they have Medicaid and you obtain the ID number.
- A person comes in and presents you with private insurance information. You receive a denial from the private insurance for no eligibility. You bill the person and they inform you of their Medicaid coverage.
- In these cases, you have 30 days from notification to submit your claims.

2. Litigation

- When litigation was involved and there was a possibility that payment for a claim may come from another source, such as a lawsuit.
- Claim must be submitted within 30 days from the time submission came within the control of the provider.
- All professional claim types must be submitted on paper.

Examples of appropriate use of Delay Reason Code 2

- Member does not have eligibility when seen, after litigation (ex: a fair hearing) it is determined Medicaid should be the payer. (Delay reason code 8 would also be appropriate since it would be a delay in eligibility).
- Member has no fault automobile insurance as primary and after litigation, the claim is not payable under auto insurance. (Delay reason code 7 would also be appropriate since it would be a delay in third party).



3. Authorization Delays

- Applies when there is a State administrative delay. Specifically, State authorized/directed delayed claim submissions due to retro reimbursement changes or system processing resolution.
- Documentation from the applicable state rate setting or policy office must be maintained on file.
- Claim must be submitted within 30 days from the date of notification.
- All claim types must be submitted on paper **except** inpatient and clinic.

Examples of appropriate use of Delay Reason Code 3

- There is a delay in a rate code being approved and added to the providers file. The provider has 30 days to submit from the date of the rate approval letter that was sent to the provider.

- If a state office gives approval to use Delay Reason Code 3. Claim must be submitted within 30 days from the letter.

- An update needs to be done to the procedure code file. Claim must be submitted within 30 days from notification of the update.

Claims Submitted for Stop-Loss Payments, HARP ADULT HOME & COMMUNITY BASED SERVICES (HCBS) & NEWBORN/MATERNAL DELIVERY SUPPLEMENTAL PAYMENTS

- **No Delay Reason Code needed on these claims – submitting these claims using Delay Reason 3 will cause the claim to be DENIED**

- All claims must be finally submitted to the Department and payable:
  - within two years from the close of benefit year for stop-loss claims **OR**
  - two years from the date of service being billed for HCBS claims **OR**
  - two years from the date of birth/delivery for Newborn/maternal supplemental claims.

4. Delay in Certifying Provider

- Valid when delay was caused by a change in the provider's enrollment status.
- Claim must be submitted within 30 days from the date of notification.

Examples of appropriate use of Delay Reason Code 4

- Provider enrollment delays due to state or other agency. The provider has 30 days from the enrollment approval letter to submit their claims.
- A specialty code, group affiliation or COS is added/updated to a provider file. Provider would submit within 30 days from the provider enrollment letter.

5. Delay in Supplying Billing Forms

- Applies to paper claims submitted using non-standard forms (no UB-04 – Institutional claim form).
- Electronic claims will deny when this reason is reported.
- Claims must be submitted within 30 days from the time submission came within provider's control.

Example of appropriate use of Delay Reason Code 5

- A provider bills electronically but a claim requires to be billed on paper with an invoice or medical records. The provider needs to request paper claims (NYS Medicaid 150003) from our fiscal agent and billing is delayed. The claims must be submitted within 30 days of receipt of the paper claims.

6. Delay in Delivery of Custom-made Appliances

- This delay reason **not accepted by NYS Medicaid**.
- Claims will deny when this reason is reported.

7. Third Party Processing Delay

- Claims must be submitted to Medicare and/or other Third Party Insurance before Medicaid.
- Applies when processing by Medicare or another payer (a third party insurer) caused delay.
- Claims must be submitted within 30 days from date submission came within provider's control.
- Paper claims must include an Explanation of Medical Benefits (EOMB).

Examples of appropriate use of Delay Reason Code 7

- Medicare and/or other Third Party Insurance payment isn't received until the claim is beyond 90 days from the date of service. If billed electronically, use the appropriate date of adjudication. If billed on paper supply the primary EOMB.
- Claim is billed beyond 90 days from the date of service to Medicaid with Delay Reason Code 7 on paper and denied for something other than timeliness (ex: claim doesn't match EOMB supplied, date of service invalid), resubmit on paper with delay reason code 7 and EOMB. **Once a claim hits a timely filing edit delay reason code 9 can not be used.**

8. Delay in Eligibility Determination

- Valid when beneficiary's eligibility date and/or coverage was changed or backdated due to eligibility determination, administrative delays, appeals, fair hearings or litigation.
- Claim must be submitted within 30 days from the date of notification of eligibility.

Examples of appropriate use of Delay Reason Code 8

- A delay in Medicaid Eligibility Determination.
- A change in Medicaid Eligibility (ex: client has 07 – emergency only coverage and went to 01 – all benefits, exception codes needed to bill the service is added to the file, date of birth is corrected).

  Anything on the client's eligibility file that is updated to cover the service being billed.

9. Original Claim Rejected or Denied Due to Reason Unrelated to the Billing Limitation Rules

- Valid for resubmitted claims when original claim and any resubmissions were submitted timely and were not denied or rejected for timeliness edits.
- Corrected claim must be submitted **within 60 days** of the date of notification. (date of the remittance)
- Delay reason is invalid for adjustments.

Examples of appropriate use of Delay Reason Code 9

- Original claim submitted within 90 days from the date of service and the claim is denied for something unrelated to timely filing.
- Original claim was submitted beyond 90 days from the date of service with a valid delay reason code and denied for something unrelated to timely filing.

**Once a claim denies for timely filing then delay reason code 9 is no longer appropriate.

10. Administrative Delay in the Prior Approval Process

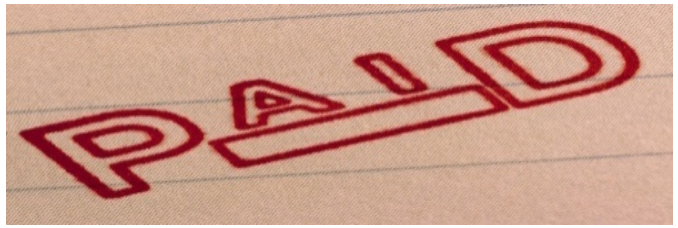
- Applies only to services/supplies requiring prior approval where prior approval is granted after the date of service due to administrative appeals, fair hearings or litigation
- Valid if claim ages over 90 days during this process.
- Claims must be submitted within 30 days from the time of notification.

11. Other

Reason code 11 should **only** be used for one of the following reasons:

A - Adjustment/Retroactive disenrollment from a Managed Care Plan
B - Audit Directed Replacement of a Voided Claim
C - Provider Initiated Replacement of a Voided Claim
D - Interrupted Maternity Care
E - IPRO Denial/Reversal

11. Other -
A -Adjustment of Paid Claim/Retro active disenrollment from a Managed Care Plan



- Paid claim requiring correction/resubmission through adjustment or void of original claim for a delay reason not listed above.
- Includes claims previously paid by a Medicaid Managed Care Plan and later recouped.
- Must be submitted within 60 days of date of notification.

Examples of appropriate use of Delay Reason Code 11 A

- Paid claim that requires correction or resubmission through an adjustment or void due to a different reason. For example, A claim was paid under one rate code and then determined it should have been another rate code – adjust the paid claim.
- Eligibility showed a Medicaid Managed Care Plan as the correct payer on the date of service and paid by plan but later recouped payment due to retroactive disenrollment.

11 Other – B - Audit Directed Replacement of a Voided Claim

- An audit agency directed provider to void an original claim and to resubmit a replacement claim for the same beneficiary & related service.
- If Date of Service is aged over 90 days when the replacement claim is submitted, reason B applies.
- Replacement claim must be submitted within 60 days from the time of notification.

Example of appropriate use of Delay Reason Code 11 B

- An audit agency (ex: OMIG, PCG, IPRO) directs a provider to void a claim and submit a new replacement claim for the same beneficiary and related service.

11. Other – C - Provider Initiated Replacement of a Voided claim

- Valid when provider, as part of their internal control and compliance plan, discovers an original claim that must be voided due to an incorrect beneficiary or provider identification (ID) number. Claim cannot be corrected by an adjustment and must be voided.
- Replacement claim with corrected ID must be submitted within 60 days from discovery of the incorrect ID, but no later than two years from the date of service.

Example of appropriate use of Delay Reason Code 11 C

- Provider internal audit finds a claim was billed under an incorrect recipient or provider ID. Since this correction can't be done through an adjustment the provider must void the claim and resubmit a new claim.

  Remember since the voided claim is **not** agency error, the replacement claim will **not** qualify for a waiver of the two-year regulation.

11. Other – D - Interrupted Maternity Care

- Use this reason for prenatal care claims delayed over 90 days because delivery was performed by a physician unaffiliated with the practitioner or physician group who gave the prenatal care.
- Claim must be submitted within 30 days from the time of notification of delivery.

11. Other – E - IPRO Denial/Reversal

- IPRO (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.
- Claim must be submitted within 30 days from the time of notification from IPRO.

15. Natural Disaster

- This delay reason can be used for delays due to natural disaster and is available for only limited use following a declaration of State Disaster Emergency in the provider's county.
- Claims must be submitted within 30 days from the time submission came within the control of the provider.

Timeliness Edits

- Enhanced claims editing that checks delay reason codes used on both original and adjustments to paid claims. If the delay reason reported does not apply, the claim is denied.

- These edits will translate to Claim Adjustment Reason/Group Code CO 29 (Time Limit for Filing has Expired) and Claim Status Code 718 (Claim/Service Not Submitted within Required Timeframe) or, for Pharmacy, NCPDP Reject Code 81 (Claim Too Old).

- Following slide shows existing edits created/modified to verify the validity of Delay Reason Codes reported on both original and adjustments to paid claims.

Timeliness Edits

Original claims and **Adjustments** to paid claims are both subject to the following existing edits:

Edit 00068 - Claim Submission Date not within required time limits (CO 29, Claim Status Code 187, NCPDP Reject 70);

Edit 00658 - Inpatient claim not submitted within required time limits (CO 29, HIPAA Claim Status Code 188);

Edit 01007 - Institutional claim not submitted within required time limits (CO 29, HIPAA Claim Status Code 187).

Timeliness Validation Edits

Edit 02157 - Delay Reason Code 1 (Proof of Eligibility Unknown) Invalid

Edit 02158 - Delay Reason Code 2 (Litigation) Invalid

Edit 02159 - Delay Reason Code 3 (Authorization Delays) Invalid

Edit 02160 - Delay Reason Code 4 (Delay in Certifying Provider) Invalid

Edit 02161 - Delay Reason Code 5 (Delay in Supplying Billing Forms) Invalid

Edit 02162 - Delay Reason Code 7 (Third Party Processing Delay) Invalid

Edit 02163 - Delay Reason Code 8 (Delay in Eligibility Determination) Invalid

Edit 02164 - Delay Code 9 (Original Claim Denied Unrelated to Timeliness Edits) Invalid

Edit 02165 - Delay Code 10 (Administrative Delay in Prior Approval Process) Invalid

Edit 02166 - Delay Reason Code 11 (Other Delay) Invalid

Edit 02223 - Delay Reason Code 15 (Natural Disaster) Invalid

How to Submit Delayed Claims

- Delayed Claims can be billed electronically or on paper claim forms submitted to CSRA (General Dynamics).
- It is the provider's responsibility to determine and report the appropriate delay reason code.
- As stated in the March 2012 Medicaid Update, page 10, New York State Medicaid and its Fiscal Agent **will not** accept requests for exceptions to these rules.
- If supporting documentation is required, submit with paper claim form and eMedNY Delay Reason Code Form.
- The required eMedNY Delay Reason Code Form can be found in pdf format (FOD – 7001)
- The Department monitors electronic claims using delay reason codes. Claim submission on paper may be requested at any time.

Resources

Information for All Providers - General Billing Guidelines:
https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf

March 2012 Medicaid Update Article (pages 7-10):

https://www.health.ny.gov/health_care/medicaid/program/update/2012/march12mu.pdf

Timely Billing information eMedNY page:

https://www.emedny.org/info/TimelyBillingInformation_index.aspx

Delayed Claim Submission Frequently Asked Questions:

https://www.emedny.org/ProviderManuals/AllProviders/PDFS/FAQs_on_delayed_claims.pdf

Contact Information

For questions related to the denial of specific claims, contact the eMedNY Call Center at **1-800-343-9000.** They have an escalation process and if needed they will reach out to Department of Health staff.

Questions???