NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS
GENERAL BILLING

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Billing for Medical Assistance Services

Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible beneficiaries be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. All such claims submitted after 90 days must be submitted within 30 days from the time submission came within the control of the provider. The HIPAA delay reasons for a claim to be submitted beyond 90 days are listed below. Providers must maintain, and upon request, provide documentation of the reason for such delay.

If a claim is returned to a provider due to data insufficiency or claiming errors (rejected or denied), it must be corrected and resubmitted within **60 days of the date of notification** to the provider. In addition, paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 60 days of the date of notification. **In most cases adjustments, rather than voids, must be billed to correct a paid claim.** Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable.

All claims must be **finally** submitted to the fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

HIPAA mandates that any claim submitted beyond the timely filing limit must include a numeric delay reason code. Paper claims submitted over 90 days from the date of service must include the scannable **eMedNY Delay Reason Code Form** available at: https://www.emedny.org/info/TimelyBillingInformation_index.aspx.
Each paper claim must have its **own eMedNY Delay Reason Code Form** attached.

HIPAA Delay Reasons with numeric codes

Claims aged over 90 days from the date of service or adjusted claims within 60 days from notification may be submitted if the delay is due to one or more of the following conditions. **It is the provider's responsibility to determine and report the appropriate delay reason code**. *The applicable numeric code must be included with all claims.*

1 Proof of Eligibility Unknown or Unavailable
This reason applies when the beneficiary's eligibility status is unknown or unavailable on the date of service due to the beneficiary not informing the provider of their eligibility. The claim must be submitted within 30 days from the date of notification of eligibility. This is not applicable to adjusted or resubmitted claims.

2 Litigation

This means there was some type of litigation involved and there was the possibility that payment for the claim may come from another source, such as a lawsuit. The claim must be submitted within 30 days from the time submission came within the control of the provider.

3 Authorization Delays

This applies when there is a State administrative delay. Specifically, State authorized and directed delayed claim submissions due to retroactive reimbursement changes or system processing resolution. The claim must be submitted within 30 days from the date of notification.

4 Delay in Certifying Provider

A change in a provider's enrollment status causes the delay. For example, back-dating of a provider's specialty code to include the date of service for a claim requiring the specialty code for payment. The claim must be submitted within 30 days from the date of notification.

5 Delay in Supplying Billing Forms

This only applies to paper claim forms, and electronic claims will deny when this reason is reported. The claim must be submitted within 30 days from the time submission came within the provider's control.

6 Delay in Delivery of Custom-made Appliances

This reason is not accepted by NYS Medicaid for delay and claims will deny when this reason is reported.

7 Third Party Processing Delay

Per regulation, claims have to be submitted to Medicare and/or other Third Party Insurance before being submitted to Medicaid. This delay reason applies when Medicare and other Third Party insurer processing caused the delay. The claim must be submitted within 30 days from the date submission came within the control of the provider and, with paper claims, include an Explanation of Medical Benefits (EOMB).

8 Delay in Eligibility Determination

This means the beneficiary's eligibility date and/or coverage was changed or backdated due to eligibility determination administrative delays, appeals, fair hearings or litigation. For example, on the date of service, MEVS reported that beneficiary was not eligible for the service. Subsequently, MEVS reported that the beneficiary was eligible on the date of service. The claim must be submitted within 30 days from the date of notification of eligibility.

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

The original claim was submitted within 90 days of the date of service and the claim was denied or rejected for some other reason. The corrected claim must be submitted within 60 days of the date of notification.

10 Administrative Delay in the Prior Approval Process

This applies only to services that require prior approval and when prior approval is granted after the date of service due to administrative appeals, fair hearings or litigation. If the claim ages over 90 days while this process is taking place, then

this reason applies. The claim must be submitted within 30 days from the time of notification.

11 Other

This delay reason applies only to the following limited situations:

A. Paid claim requiring correction or resubmission through adjustment of original claim for a delay reason not listed above. Must be submitted within 60 days of date of notification.
B. An audit agency directed the provider to void an original claim and to resubmit a new replacement claim for the same beneficiary and related service. If the date of service is over 90 days when the replacement claim is submitted, this reason applies. The replacement claim must be submitted within 60 days from the time of notification.
C. The provider, as part of their internal control and compliance plan, discovers an original claim which was submitted within 90 days of the date of service that has to be voided due to an incorrect beneficiary or provider identification (ID) number. Such claims cannot be corrected by an adjustment and must be voided. The replacement claim with the corrected ID must be submitted within 60 days from the time of discovery of the incorrect ID, but no later than two years from the date of service. Because the voided claim is **not** agency error, the replacement claim will **not** qualify for a waiver of the two-year regulation.
D. Interrupted maternity care – Use this reason for prenatal care claims delayed over 90 days because delivery performed by a different practitioner.
E. IPRO (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.

Claims Over Two Years Old

All claims **over two years** old must be submitted directly to the fiscal agent **within 60 days** of the date submission came within control of the provider. Those claims will be automatically denied and a denial message (Edit 01292, Date of Service Two Years Prior to Date Received, or HIPAA reject reason code 29 or 187, the time limit for filing has expired) will appear on the provider's remittance statement or 835 electronic remittance advice. The Department will *only* consider claims over two years old for payment if the provider can produce documentation verifying that the cause of the delay was the result of errors by the Department, the local social services districts, or other agents of the Department. In addition, payments will be made for claims submitted in circumstances where a court has ordered the Department to make payment.

If a Provider believes that claims denied for edit 01292 are payable due to one of the reasons above, they may request a review. Requests for waiver of the regulation regarding submission of claims greater than two years from the date of service must then be **received** at the address below **within 60 days of the date on the remittance advice** with supporting documentation to:

New York State Department of Health
Two Year Claim Review
150 Broadway, Suite 6E
Albany, New York 12204-2736

Supporting documentation (cover letter of explanation, remittance statements, notice of eligibility, fair hearing decision, court order decisions, evidence of agency error, etc.) and a copy of the current remittance statement documenting the edit 01292 denial must accompany your written request.

Claims submitted for review without the appropriate documentation, or those not submitted within the 60 day time period for review, will not be considered.

When a provider **voids** a previously paid claim and now wishes to resubmit, the resubmission is treated as a **new claim** and will be subjected to the criteria above for the submission of claim(s) over two years old. All timely submission rules apply. The new claim will not be considered as an agency error and, therefore, **will not** qualify for a waiver of the two-year regulation. Adjustments, rather than voids, should always be billed to correct a paid claim(s).

Claims Submitted for Stop-Loss Payments

All claims for Stop-Loss payment must be finally submitted to the Department, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department.

The Department will *only* consider Stop-Loss claims **over two years from the close of the benefit year*** for payment if the provider can produce documentation verifying that the cause of the delay was the result of agency error or a Court-ordered payment.

* Please note that for Two Year Waiver purposes **the close of the benefit year** is defined as the earliest of:

- the last day of the beneficiary's plan enrollment; or
- the last day of the beneficiary's Medicaid eligibility; or
- the beneficiary's date of death; or
- the last calendar day of the benefit year.

Claim Certification Statement

Provider certifies that:

- I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim;
- I have reviewed this form;
- I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations;
- The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program;
- Payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid;
- All statements made hereon are true, accurate and complete to the best of my knowledge;
- No material fact has been omitted from this form;
- I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact;
- Taxes from which the State is exempt are excluded;
- All records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefore shall be promptly furnished upon request to the local departments of social services, the DOH, the State Medicaid Fraud Control Unit of the New York State Office of Attorney General or the Secretary of the Department of Health and Human Services;
- There has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion;
- I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to
    - (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and
    - (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the DOH as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Provider Manuals and other official bulletins of the Department.

I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid Program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.