# Timely Filing

## PURPOSE

ND Medicaid requires providers to submit claims in accordance with the timely filing requirements of North Dakota Administrative Code 75-02-05-04.7.

## APPLICABILITY

ND Medicaid tracks timely filing based on the date ND Medicaid receives the claim. When the claim is received a receipt is captured as a Julian date.

ND Medicaid must receive an **original** Medicaid primary claim within one hundred eighty (180) days from the date of service. This time limit may be extended for the following reasons:

- Original claims with retroactive member or provider eligibility;
- Original claims with third-party liability;
- Original Medicare crossover claims; and
- Claims submitted for reconsideration.

The provider is responsible for providing proof of timely filing at the time of claim submission. Documents accepted as proof of timely filing include:

- ND Medicaid Transaction Control Number (TCN) and Remittance Advice Date;
- Medicare/Third Party Explanation of Benefits;
- Letter of retroactive eligibility from ND Medicaid; or
- A returned date stamped claim from ND Medicaid.

ND Medicaid does not accept the following documents as proof of timely filing:

- Computer-generated reports from the provider's office or billing software;
- Claims previously denied for timely filing; or
- Notification from the provider's office that claims were being held and not submitted for denial/payment.

All claims must be submitted by an enrolled provider and contain the appropriate name and all required provider identifiers.

### Original Claims with Retroactive Member or Provider Eligibility

ND Medicaid extends timely filing for original claims when either a member or provider has retroactive eligibility.

- For retroactive member eligibility, claims must be received within one hundred eighty (180) days from the date of the eligibility determination by ND Medicaid; and

- For newly enrolled providers, claims must be received within one-hundred eighty (180) days of the date that retroactive provider eligibility was authorized by ND Medicaid.

Claims with retroactive provider eligibility must be submitted with the letter of retroactive eligibility from ND Medicaid. Claims with retroactive member eligibility do not need an attachment.

## Original Claims with Third-Party Liability (Excludes Medicare Crossovers)

- ND Medicaid must receive an **original secondary/tertiary** claim submission within three hundred sixty-five (365) days from the date of service. Claims must be submitted with third party payment information on the claim. This time limit may be extended only when there are situations involving member or provider retroactive eligibility. For member retroactive member eligibility, claims must be received within one hundred eighty (180) days from the date of the eligibility determination by North Dakota Medicaid.
- For newly enrolled providers, claims must be received within one hundred eighty (180) days of the date that retroactive provider eligibility was authorized by North Dakota Medicaid.

**Note:** If the timely filing deadline for retroactive eligibility occurs before the original secondary/tertiary timely filing guideline of three hundred sixty-five (365) days then the deadline of three hundred sixty-five (365) days will apply.

## Original Medicare Crossover Claims

ND Medicaid must receive an **original Medicare crossover** claim submission within one hundred eighty (180) days from the date on the Medicare Explanation of Benefits (EOB). Claims must be submitted with Medicare payment information on the claim. This time limit may be extended only if there are situations involving member or provider retroactive eligibility.

- For retroactive member eligibility, claims must be received within one hundred eighty (180) days from the date of the eligibility determination by North Dakota Medicaid; or
- For newly enrolled providers, claims must be received within one-hundred eighty (180) days of the date that retroactive provider eligibility was authorized by North Dakota Medicaid.

**Note:** For Medicare primary claims crossing directly over to Medicaid, providers must wait 60 days from the Medicare EOB date before submitting a claim. Crossover transactions can take up to 60-90 days. If Medicaid pays the provider for a claim submitted by the provider prior to Medicare's adjudication; providers must adjust the

claim to allow ND Medicaid to process the claim with the Medicare payment information. Any duplicate payments must be voided with ND Medicaid.

## Claims Submitted for Reconsideration (Replacement, Resubmission, or Void Claims)

If the original claim submission timely filing requirements (claims were filed within 180 days or met the above exceptions) were met, providers may file claims for reconsideration (replacement, resubmission, or void claims) within three hundred sixty-five (365) days from the date of service.

All replacement, resubmission, and void claims must contain the Medicaid remittance advice date and TCN of the original claim processed to prove the original claim was submitted in accordance with timely filing requirements. The TCN and RA date must be submitted in the notes section of the claim.

This time limit may be extended only when one or more of the following situations exist:

- Replacement or resubmission of claims are received within one hundred eighty (180) days of any provider rate update if a ND Medicaid generated mass adjustment was not created;
- Replacement, resubmission, or voids are submitted and received within one hundred eighty (180) days of any retroactive member eligibility or provider eligibility for newly enrolled providers;
- Replacement or resubmission of claims are received within one hundred eighty (180) days from an adjustment notice (EOB) from Medicare or a third-party payer who has previously processed the claim for the same service. The adjustment notice must be dated after the ND Medicaid timely filing period. A copy of the adjustment notice (EOB) from the primary payer must be attached to each claim replacement, resubmission, or void;
- Replacement or resubmission of claims that were erroneously adjudicated by ND Medicaid; or
- Replacement or resubmission of orthodontic claims in which the primary dental insurance terminated before treatment was completed and ND Medicaid would be responsible for making additional payment. Providers will have (180) days from the last primary payers EOB date to adjust the previously processed claim.

Timely claim filing limits do not apply when there are:

- Replacement, resubmission, or voids resulting in an ND Medicaid overpayment; or
- ND Medicaid generated mass adjustments. Note: Provider replacement, resubmission or void of a mass adjustment claim must be submitted within timely

filing requirements. A mass adjustment of claims by ND Medicaid does not extend timely filing requirements.

### Program Integrity Unit/Surveillance and Utilization Review Section (SURS) Audits

Claims adjusted due to a Program Integrity Unit/SURS audit may not be resubmitted unless providers have received written authorization in the audit recovery notice from Program Integrity Unit/SURS to resubmit corrected claims.

If providers received written authorization in the audit recovery notice to resubmit corrected claims, providers have ninety (90) days from the date of the Medicaid remittance advice that includes the recoupments to submit corrected claims.

Providers will be required to include the Medicaid remittance advice date and TCN of the state adjusted claim, and a copy of the written audit recovery notice with each corrected claim submission.

### Appeals

A provider may request a review of denial of payment under this section by filing a written request for review with the department within thirty (30) days of the date of the department's denial of payment. The written request for review must include the remittance advice or the notice of recoupment or adjustment and a statement of each disputed item with the reason or basis for the dispute.

A provider may not request review under this section of the rate paid for a particular service or for a full or partial denial, recoupment, or adjustment of a claim due to required federal or state changes, payment system defects, or improper claims submission. (See N.D.C.C. section 50-24.1-24(2)).

If a claim is filed within one year of the date of service but denied for timely filing due to a failure to establish that the original claim was filed within 180 days from the date of service (the claim does not include a copy of a TCN/RA establishing submission of a timely original claim), the appeal cannot be filed until such time as the provider resubmits for processing a claim with proof of timely filing of the original claim.

## Timely Filing Override Request Form

ND Medicaid will consider overrides to timely filing submitted on the Timely Filing Override Request Form. This form does not replace the current appeals, reconsideration, or resubmission process. Providers must include a reason for the timely filing override and provide supporting documentation.

ND Medicaid may consider timely filing overrides for the following reasons:

- The claim was listed on an ND Medicaid accepted claim report and showed no errors but was not processed or returned:
  - Providers must include a report that both the clearinghouse and ND Medicaid accepted the claim without errors. A report from only the clearinghouse will not be accepted as a reason to override timely filing; and
  - Cover sheets attached to returned paper claims cannot be used as proof of timely filing.
- Member identification card was not obtained:
  - Providers must include documentation of at least three (3) attempts to obtain identification from the member. The provider must additionally provide documentation that the Medicaid portal was accessed within the timely filing limits and did not return Medicaid eligibility information.
- Insurance information was not disclosed:
  - Providers must include documentation signed by the member stating that they had no other insurance on the date of service.
- Other reasons not listed.

Requests submitted for the following reasons will not be considered and the claim will be denied:

- Claim submitted with incorrect ID or patient name. Claims submitted and processed under an incorrect patient and/or member ID must be voided and a new claim must be received before the timely filing deadline;
- Rejected or returned claims that do not meet the standard for processing a claim; and
- Provider system issues and/or human errors which caused the claim or late charges to be filed outside timely filing limits.

## DEFINITIONS

*Claim* – A bill for one or more services for one beneficiary

*Original Claim* – First claim submission

*Mass Adjustment* – Adjustment generated by ND Medicaid.

*Replacement Claim* – Replacement (Adjustment) of a previously processed claim.

*Resubmission Claim* – Resubmission of a previously processed denied claim.

*Timely Filing Override Request Form* – Form that may be submitted to request a timely filing override for exceptions that fall outside of what has been outlined in the policy. This form is only to be used for limited reasons (see form for further details).

*Transaction Control Number (TCN)* – 17-digit claim number.

*Void Claim* – Reversal of a previously processed claim.

## REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

## FREQUENTLY ASKED QUESTIONS

**Q:** What if a member didn't tell me about their primary insurance and the original timely filing period has been exhausted?
**A:** Timely claims filing applies even if a claim is received after the filing limit due to the member not disclosing a primary insurance to the billing provider.

**Q:** I am making a change to my provider enrollment record for a currently enrolled provider and want to hold claims until after the enrollment change is processed. Will ND Medicaid consider claims timely if I hold the claims until after the enrollment change is complete?
**A:** No. ND Medicaid does not extend timely filing when a provider elects to hold claims for a currently enrolled provider.

## CONTACT

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## POLICY UPDATES

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| Section | Updates |
|---|---|
| | Format updates and clarifications added throughout |