

Timely Filing Policy

North Dakota Medicaid follows the timely filing requirements of 42 Code of Federal Regulations 447.45(d).

- For new claims submitted to ND Medicaid, providers have one year from the date of service to submit the claim(s).
- The date of receipt of a claim is captured as a Julian date. Electronic claims are automatically provided a Julian date; Julian dates are assigned to paper claims based on the date they are received at ND Medicaid.
- A provider has to be enrolled and submit a claim with the appropriate name and provider number in order to establish timely filing.
- For a processed claim, providers have one year from the last remittance advice date to resubmit or adjust claims(s).
 - A claim that has been denied or has a denied line may be adjusted.
 - When resubmitting a denied claim, the Transaction Control Number (TCN) and remittance advice date of the previously processed claim are required in box 22 of the HCFA claim form and box 80 of the UB claim form or the equivalent loop and segment of the 837.
 - Adjustments, which resulted in the provider receiving an overpayment, may be submitted up to two years after the date of the remittance advice.
 - Adjustments, which resulted in the provider being underpaid, must be submitted within one year of the date of the remittance advice.
 - When submitting adjustments, the TCN and remittance advice date of the previously processed claim are required.
- For Medicare crossover claims, providers have six months from the date on the Medicare Explanation of Benefits (EOB) to submit.
- For Medicare primary claims crossing over to Medicaid, providers must wait 60 days from the Medicare EOB date before submitting a paper claim. The actual transaction can take from 60-90 days. If Medicaid inadvertently pays the provider for the crossover claim and the claim submitted by the provider, providers must adjust the claim requesting that ND Medicaid recoup the duplicate payment. ND Medicaid may periodically audit this requirement.
- ND Medicaid will not accept computer-generated reports from the provider's office as proof of timely filing. The only documentation that will be accepted is a ND Medicaid remittance

MEDICAL SERVICES

advice, Medicare/Third party Explanation of Benefits, letter of retro-eligibility and/or a returned date stamped claim from ND Medicaid.

- The timely filing requirement for ND Medicaid is one year to the day from the date of service or one year to the day of the most recent remittance advice. The remittance advice date and corresponding TCN need to be provided on the paper claim or 837 submissions. A claim that has previously denied for timely filing cannot be used to prove timely filing.
- The timely filing requirement for ND Medicaid for a claim that was paid and subsequently recouped from Medicaid Expansion/Sanford Health Plan is one year to the day from the date of the remittance advice from Medicaid Expansion/Sanford Health Plan showing the recoupment of payment of the claim. A copy of the remittance advice from Medicaid Expansion/Sanford Health Plan must be submitted with the claim.
- The one year timely filing still applies if a claim is received after the one-year filing limit due to the recipient not disclosing a primary insurance to the billing provider. In such a situation, the one-year timely filing limit applies from the date of service, not from the date of the remittance advice showing the primary insurance payment or denial.

Created: December, 2013

Updated: July 2017; September 2019 (format only)