



Timely Filing Frequently Asked Questions

The following frequently asked questions focus on common issues providers have when trying to better understand the rules and exemptions for timely filing. Additional information on timely filing is also available in the General Billing and Forms Manual, Section 3.3, available here <http://www.vtmedicaid.com/#/manuals>.

What is the date used when considering timely filing deadlines?

A claim is considered filed when the fiscal agent documents receipt of the claim. Claim receipt is documented by the assignment of an Internal Control Number (ICN).

What should providers do if the window for timely filing is expiring?

Providers are required to submit the initial claim timely, even if the expected result is a denial.

What if I contacted the Department or fiscal agent and I'm still waiting for a response?

Waiting for prior authorization or correspondence from the Department or the fiscal agent is not an acceptable reason for late filing. Phone calls and other correspondence are not proof of timely filing. The claim must be submitted, even if the expected result is a denial.

What if there was an issue with my vendor?

Issues resulting in failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner must be addressed. If the issue is between the provider and the software vendor, billing agent or clearinghouse, this does not constitute an acceptable reason to be outside the timely filing period.

What if my claim was lost in the mail?

Providers are responsible for assuring that each claim is received within the timely filing period. If claim information does not appear on the Medicaid RA within 30 days of an electronic transmission or a paper claim mailing and the claim has not been returned in the mail, the provider can contact the fiscal agent to determine the status of the claim and resubmit the claim if necessary.

Should I attach the Medicare EOB to prove timely filing?

Yes, if your claim did not crossover from Medicare then a paper claim with The Medicare Attachment Summary Form (MASF) and/or the Medicare EOB should be attached showing the Medicare paid date. If Medicare denied your claim, then a paper claim with the Medicare EOB should be attached showing the Medicare denied date. Failure to submit the MASF and/or the Medicare EOB within 180 days from Medicare's paid or denied date will result in a timely filing denial. Both the MASF and the Medicare EOB are required for claims with dates of service over 2 years old.

Is a paper submission required when submitting a corrected claim?

Providers are strongly encouraged to submit corrected claims electronically within 180 days from the initial denial if none of the following has changed:

- Member UID
- Billing Provider ID
- Procedure Code
- To or From Date of Service

The system is set up to recognize the corrected claim and not deny for timely filing if none of the above has changed. If any of the above has changed and the claim is within 180 days from the initial denial date a paper claim must be submitted with a copy of the initial RA. A note must be present in Field 19 on the CMS 1500 or Field 80 of the UB-04 stating "corrected claim". A written explanation on the Medicaid RA explaining the change is also required.

If it's more than 180 days from the initial denial date a paper claim is not necessary as it will not override the timely filing denial. Your claim can be submitted electronically in this case. Electronic claims process quicker than paper claims and is the preferred method for claim submissions.

Once you receive a timely filing denial a reconsideration request can be submitted with all pertinent documentation and an explanation of why it took longer than 180 days from the initial denial date to address the claim issue/denial.

Is a paper submission required when submitting a claim that was previously adjusted?

If you submitted an adjustment request with a new claim attached for reprocessing that denied for something other than timely filing, you should submit a paper claim if it's within 180 days from the adjustment date with a copy of your adjusted RA. A note must be present in Field 19 on the CMS-1500 or Field 80 of the UB-04 stating "adjusted claim".

If it's more than 180 days from the adjustment date a paper claim is not necessary as it will not override the timely filing denial. Your claim can be submitted electronically in this case. Once you receive a timely filing denial a reconsideration request can be submitted with all pertinent documentation and an explanation of why it took longer than 180 days from the initial denial date to address the claim issue/denial.

When should I submit a timely filing reconsideration request?

Timely filing is only overridden when an extenuating circumstance beyond the provider's control prevented the claim from being filed timely or the provider can prove they were actively trying to resolve their claim denials. A detailed explanation of the extenuating circumstance or follow-up activity should be clearly documented in your request letter.

Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not extenuating circumstances beyond the provider's control. Claim transmission errors, claims lost in the mail or claims that are continually resubmitted without addressing the denial do not constitute an override of a timely filing denial.

What are acceptable forms of documentation to prove timely follow-up of claims when submitting a timely filing reconsideration request?

Acceptable documentation would include system account notes, call reference numbers or emails with the Department or fiscal agent. A summarization of events is helpful; however, it is not accepted as proof of timely follow-up.