NORTH Dakota | Human Services

Be Legendary.™

Timely Filing Policy

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

- 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 must be enrolled and submit a claim with the appropriate name and provider number to establish timely filing.
- 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 advice, Medicare/Third party Explanation of Benefits, letter of retro-eligibility and/or a returned date stamped claim from ND Medicaid.
- 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.
- Timely filing still applies if a claim is received after the filing limit due to the member not disclosing a primary insurance to the billing provider. In such a situation, the timely filing limit applies from the date of service, not from the date of the remittance advice showing the primary insurance payment or denial.

Original Claims Without Medicare or Third-Party Liability

ND Medicaid must receive a provider's **original** Medicaid primary claim submission within one hundred eighty (180) days from the date of service. This time limit may be extended only when one or more of the following situations exist.

- Claims are submitted and received within one hundred eighty (180) days of any retroactive member eligibility regardless of the date of service.
- Claims are submitted and received within one-hundred eighty (180) days of any retroactive provider eligibility regardless of the date of service.

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

ND Medicaid must receive a provider's **original secondary/tertiary** claim submission within three hundred sixty-five (365) days from the date of service. This time limit may be extended only when one or more of the following situations exist.

- Claims are submitted and received within one hundred eighty (180) days of any retroactive member eligibility regardless of the date of service.
- Claims are submitted and received within one hundred eighty (180) days of any retroactive provider eligibility regardless of the date of service.

NOTE: If the timely filing guideline for the retroactive eligibility of one hundred eighty (180) days occurs before the original secondary/tertiary timely filing guideline of three hundred sixty-five (365) days then the three hundred sixty-five (365) days will apply.

Original Medicare Crossover Claims

- Medicare crossover claims, providers have one hundred eighty (180) days from the date on the Medicare Explanation of Benefits (EOB) to submit to ND Medicaid.
- For Medicare primary claims crossing over to Medicaid, providers must wait 60 days from the Medicare EOB date before submitting a 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.

Final Submission of Claims

Final submission of claims that will be considered for adjudication (including replacement, resubmission, or void claims) must occur within three hundred sixty-five (365) days from the date of service. This time limit may be extended only when one or more of the following situations exist.

- Replacement, resubmission, or voids that resulted in a ND Medicaid overpayment will have no time limit.
- ND Medicaid generated mass adjustments (does not include provider submitted replacement, resubmission, or void of a mass adjustment) will have no time limit.
- Replacement or resubmission of claims must be submitted and received within one hundred eighty (180) days of any provider rate update if 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 or provider eligibility regardless of the date of service.
- Replacement or resubmission of claims must be submitted and 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, and the adjustment notice is dated after the ND Medicaid timely filing periods described above. 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.

NOTE: ND Medicaid audits are excluded, see audit section below

ND Medicaid Audits

Claims that were adjusted by ND Medicaid **due to an audit** cannot be replaced or resubmitted unless the following situation exist.

- ND Medicaid generated adjustments due to an audit will have no time limit.
- Providers receive written notification from the ND Medicaid that they will be allowed to replace or resubmit corrected claims. Providers will be required to attach a copy of the written notification with each claim resubmission.

If one or more of the above audit conditions are met, providers will have ninety (90) days from the written notification date to resubmit corrected claims.

Glossary of Terms

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.

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

Void Claim – Reversal of a previously processed claim.

Created: December 2021