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Re: Public comments received for GCR 18-070 Timely Filing Guidelines Update

Comments were submitted jointly by a group of organizations: Bi-State Primary Care Association, Dartmouth Hitchcock Medical Center, Vermont Association of Hospitals and Health Systems, and the Vermont Medical Society.

General

Comment 1: The new update provides timeframes in terms of months, not days. It is unclear whether 6 months equals 180 days or 6 months from the date regardless of the number of days in a given month (for example, 6 months may be longer if the date of service is June rather than February). Please clarify how this will be measured.

Response 1: Thank you for this request for clarification. One month equals 30 days on average, therefore 6 months equals 180 days. The final timely filing guidelines have been adjusted accordingly to clarify this.

Comment 2: There is a 30-day required waiting period for Medicaid claims. This means that the 6 months is really 5 months. Can DVHA please clarify if the intent is to allow 5 or 6 months?

Response 2: The 30-day waiting period for Medicaid claims allows for processing time of Medicare crossover claims, thereby reducing the potential burden of claim denials due to lack of primary payment. DVHA expects that providers will be able to submit claims timely within 6 months from the date of service despite this waiting period.

When Medicare is Primary

Comment 3: DVHA proposes that when Medicare is primary, a provider has “6 months from Medicare’s paid date to submit a claim or 6 months from Medicare’s denied date to submit a claim.” In our phone conversation, DVHA clarified that the 6 months could run beyond 12 months of the date of service and 42 CFR 447.45 (d)(4)(ii) is clear that the 6 months from Medicare disposition is an exception to the requirement to file claims within 12 months of the DOS.

Therefore, we request a clarification that a provider has “12 months from the date of service, or 6 months from Medicare’s paid date to submit a claim or 6 months from Medicare’s denied date to submit a claim, whichever is later.”

Response 3: DVHA declines to modify this guidance as it believes 6 months is sufficient time to submit a Medicaid claim after Medicare disposition. When other insurance (excluding Medicare) is the primary insurer, providers have 12 months from the date of service to submit a claim. When Medicare is the primary insurer, providers have 6 months from Medicare's disposition to submit a claim.

Provider Retroactive Enrollment

Comment 4: We appreciate your clarification in the GCR that in instances of provider retroactive enrollment, providers have 12 months from the date of services or an additional 45 days from the date of notice of enrollment to submit a claim. For additional clarification, we still suggest adding the clause, "whichever is later" at the end of this provision.

Response 4: This clarification has been added to the final guidance in GCR Final Policy 18-070 and will be reflected in the [Medicaid Provider Manual](#).

Corrections to Denied Claims & Submitting Timely Filing Appeals/Reconsiderations

Comment 5: Throughout the timely filing requirements, the number of timely filing categories and inconsistencies between the timeframes for submitting claims cause confusion and create substantial implementation burdens. Compliance will be especially challenging with submitting timely filing appeals/reconsiderations within three months as practices and health care facilities do not tend to track appeals based on the reason for denial/appeal. Additionally, there are several dental practices that file, and receive back, paper claims, which adds significant time to process. As a starting point for increasing consistency and reducing administrative costs with compliance, we suggest a consistent six-month timeframe to both correct denied claims and submit a timely filing appeal/reconsideration.

Response 5: It is DVHA's expectation that denied claims are addressed in a timely manner and considers 3 months to be a reasonable amount of time in order to revise and resubmit denied claims. This is in line with the length of time that other states permit as well.

The 3-month timely filing reconsideration request timeframe is not a change in current practice, and DVHA is not aware of systemic issues regarding this timeframe. Providers with proof of extenuating circumstances may request an override.