



State of Vermont  
Agency of Human Services  
280 State Drive, Center Building  
Waterbury, VT 05671-1000

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# Global Commitment Register

October 8, 2018

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GCR 18-070  
PROPOSED

## **Timely Filing Guidelines Update**

### **Policy Summary:**

The Department of Vermont Health Access (DVHA) will be updating the Medicaid timely filing guidelines for provider claims to better align with federal regulations. There will be changes to the timeframes in which providers can submit claims for reimbursement. Changes from the current timely filing guidelines will primarily affect:

- Claims when Medicaid is not the primary insurer,
- Claims for a provider or beneficiary who was retroactively enrolled,
- Corrections to denied claims, and
- The time limit for providers to file appeals/reconsiderations for claims.

Draft new language on timely filing for the Medicaid Provider Manual can be found under “Additional Information” below.

**Effective Date:** February 1, 2019

### **Authority/Legal Basis:**

[Medicaid State Plan](#)  
[42 CFR §447.45](#)

**Population Affected:** All Medicaid

**Public Comment Period:** October 8, 2018 – November 8, 2018

Send comments to:

Medicaid Policy Unit  
280 State Drive, Center Building  
Waterbury, VT 05671-1000

Or submit via e-mail to [AHS.MedicaidPolicy@vermont.gov](mailto:AHS.MedicaidPolicy@vermont.gov).

There is no public meeting scheduled at this time. If one should be scheduled, that information can be found at: <http://dvha.vermont.gov/> either through the calendar or listed under upcoming events.

### **Additional Information:**

The [Medicaid Provider Manual](#), which contains the current timely filing guidelines in Section 8.2, can be found at this link. The Provider Manual will be updated with the new language when the change becomes effective.

New draft language for timely filing of claims is as follows:

- When Medicaid is the primary insurer providers have 6 months from the date of service to submit a claim.
- When Medicare is the primary insurer providers have 6 months from Medicare's paid date to submit a claim or 6 months from Medicare's denied date to submit a claim.
- When other insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim.
- For an inpatient claim, providers have 6 months from the discharge date to submit a claim.
- When a provider has been granted retro-enrollment they have up to 12 months from the date of service, or an additional 45 days from the date of notice of enrollment to submit a claim.
- When a recipient has been granted retro-eligibility providers have 12 months from the date of service to submit a claim.
- Providers must request an adjustment to a PAID claim within 12 months from the original paid date when the adjustment would **result in a positive financial outcome for the provider**.
- Providers may request an adjustment to a PAID claim within 3 years from the original date of service when the adjustment would **result in a negative financial outcome for the provider**. If the claim is more than 3 years old, providers must refund the overpayment by completing the refund form and attaching the refund check. The Medicaid Refund form is available on our website at <http://www.vtmedicaid.com/#/forms>.
- Providers have 6 months from the initial Medicaid denial to submit a corrected claim.
- Providers have 3 months from the initial Medicaid timely filing denial to submit a timely filing reconsideration request.