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TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **February 18, 2014**

SUBJECT: **Fast Track Regulations - Timely Claims Filing (4103/6801)**

I am in receipt of the attached regulations regarding Timely Claims Filing for Fee-For-Service Providers (12 VAC 30-95 (new chapter)). You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations and if these regulations comport with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325 has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

Because the promulgation of these regulations will amend the State Plan, approval by CMS will also be required. If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esquire

Attachment

Project 3170 - Fast-Track

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Timely Claims Filing

CHAPTER 95

STANDARDS ESTABLISHED AND METHODS USED FOR FEE-FOR-SERVICE REIMBURSEMENT

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The requirements of this Chapter shall operate in addition to the provider requirements set out in other Chapters, including but not limited to, 50 through 90 of the Virginia Administrative Code, Title 12, for DMAS.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-95-10. Timely claims filing.

A. Definitions. The following words and terms used in this regulation shall have the following meaning unless the context clearly indicates otherwise.

"Claim" means a bill or a line item for services, drugs or devices as that term is defined in 42 C.F.R. § 447.45.

"Submit" or "submission" or "file" or "filing" means actual, physical receipt by DMAS that is documented in DMAS records.

B. Consistent with 42 CFR § 447.45, providers shall submit all claims to DMAS no later than 12 months from the date of service for which the provider requests reimbursement. In the absence of the two exception conditions set out below, all claims otherwise submitted to DMAS after this 12 month time limit shall be denied.

C. In cases where the actual receipt of a claim by DMAS is undocumented, the burden of proof shall be on the provider to show that the claim was actually, physically received by DMAS.

Proof by the provider that a claim was mailed, transmitted or conveyed to DMAS by any method shall not constitute proof of receipt. The provider shall confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim.

D. If a claim for payment under Medicare has been filed in a timely manner, DMAS may pay a Medicaid claim for the same service within six months after the provider receives notice of the disposition of the Medicare claim.

E. Exceptions.

1. For cases in which a provider's claim was retracted by the third party payor, DMAS shall consider the date of the retraction notice by the third party payor as the begin date of the initial 12 month timely filing period.

2. For cases of retroactive Medicaid eligibility, DMAS shall consider the date of the notification of delayed eligibility from the local department of social services as the begin date of the initial 12 month timely filing period.

F. If DMAS denies a provider's original claim for reimbursement, the provider may resubmit the claim for reconsideration, together with any and all documentation to support the previously denied claim. All supporting documentation shall be filed at the time of the claim resubmission. DMAS shall not reconsider any resubmitted claim where:

a. The previously denied claim was not originally submitted within 12 months of the date of service, or

b. The denied claim was not re-submitted to DMAS within 13 months of the date the original claim was initially denied.

G. DMAS' decision to deny a resubmitted claim shall be final.