Submitting Claims over Two Years Old

All claims must be **finally** submitted to eMedNY and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

All claims **over two years** old must be submitted directly to eMedNY within 60 days of the date submission came within control of the provider. Those claims will be automatically denied, and the following message will appear on the provider's paper remittance statement or 835 electronic remittance advice. (On Paper Remits: Edit 01292; Date of Service Two Years Prior to Date Received. On the 835 Electronic Remittance: Claim Adjustment Reason Code (CARC) 29; The time limit for filing has expired. On a 277 Claim Status Response, Claim Status Code (CSC) 187; Date(s) of service.) The Department will only consider claims over two years old for payment if the provider can produce documentation verifying that the cause of the delay was the result of errors by the Department, the local social services districts, or other agents of the Department. In addition, payments will be made for claims submitted in circumstances where a court has ordered the Department to make payment.

Two-year waiver requests will be accepted electronically by FAX or email as well as by postal mail. Two-year waiver requests for claims payment are considered when the submission of claims is greater than two years from the date of service. Requests and supporting documentation must be received within 60 days of the date on the remittance advice.

Written requests may be submitted in the following ways:

FAX	518-473-6708
Secure email	pend@health.ny.gov
Mail paper submissions	New York State Department of Health Two Year Claim Review 1 Commerce Plaza, Room 1206 Albany, NY 12260

Supporting documentation (cover letter with explanation of delay and sequence of events, remittance statements, notice of eligibility, fair hearing decision, court order decision, evidence of agency error, etc.) and a copy of the current remittance advice documenting the edit 01292 denial must accompany all requests. Claims submitted for review without the appropriate documentation, or those **NOT** submitted within the 60-day time period for review, will **NOT** be considered.

Voiding and Adjusting of Paid Claims

When a provider **voids** a previously paid claim and now wishes to resubmit, the resubmission is treated as a **new claim** and will be subjected to the criteria above for the submission of claim(s) over two years old. All timely submission rules will apply. The voided claim **will not** be considered as an agency error and, therefore, the new claim **will not** qualify for a waiver of the two-year regulation. **Adjustments, rather than voids, should always be billed to correct a paid claim(s).**

Claims Submitted for Stop-Loss Payments

All claims for Stop-Loss payment must be finally submitted to eMedNY and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department. The Department will *only* consider Stop-Loss claims **over two years from the close of the benefit year*** for payment if the provider can produce documentation verifying that the cause of the delay was the result of agency error or a Court-ordered payment.

* **Please note** that for a Two Year Waiver **the close of the benefit year** is defined as the earliest of:

- the last day of the beneficiary's plan enrollment; or
- the last day of the beneficiary's Medicaid eligibility; or
- the beneficiary's date of death; or
- the last calendar day of the benefit year

Refer to the General Billing section of your Provider Manual for information on timely submission of claims.