

# Changes to Medicare Timely Filing Guidelines

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service.

Dates of Service	NEW Timely Filing Deadline
October 1, 2008 through September 30, 2009	December 31, 2010 (27 months)
October 1, 2009 through December 31, 2009	December 31, 2010 (15 months)
Beginning January 1, 2010	12 months from the Date of Service

In accordance with Medicare guidelines, Medicare systems will reject/deny claims that are not received within the specified time requirements. When a claim is denied for having been filed after the timely filing period, such denial does not constitute an “initial determination”. As such, the determination that a claim was not filed timely is not subject to appeal. Therefore, providers should not submit a request for redetermination to the Appeals department.

When a claim is received from a provider paid on a cost basis where only part of the services were filed within the timely filing period, the entire claim will be rejected. The provider may resubmit the services, splitting them into two claims with discrete periods before and on or after October 1.

## What happens if the claim is Returned to Provider (RTP)?

When a claim is returned for correction, the resubmission of the claim must be done within the specified time requirement. If the resubmission is not filed within the specified time requirement, the claim will be rejected/denied.

## What happens if the claim was suspended?

Where a contractor has suspended a claim and allowed a period for submission of corrections, the timely filing requirements will have been met if the corrections are received within the allotted time.

## Does an adjusted claim have to be submitted within the timely filing requirements?

If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim.

There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system (PPS), if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

Currently, no exceptions have been established to extend the timely filing requirements. Please be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

*The information provided was current as of April 1, 2010.*

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