PT 25-09

STATE OF MARYLAND
DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
General Provider Transmittal No. 71
January 21, 2009

To: All Providers

From: Susan J. Tucker, Executive Director
Office of Health Services

Note: Please ensure that the appropriate staff members in your organization are informed of the contents of this memo.

Re: Time Limit for Submitting Claims
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The Maryland Medical Assistance Program has made changes to the regulation that specifies the time frame for submitting claims to the Fee-for-Service Program. Specifically, COMAR 10.09.36.06 has been changed to allow providers twelve (12) months to submit claims. The specific regulation is cited below or can be viewed at: http://www.dsd.state.md.us/comar/10/10.09.36.06.htm.

10.09.36.06

.06 Billing Time Limitations.

Unless specified in Regulation .03A(1) of this chapter, the following apply:

A. The Department may not reimburse the claims received by the Program for payment more than 12 months after the date of service.

B. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:

(1) Approved, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

(2) Denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

C. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 12 months of the earliest date of service.

D. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 12-month period, or within 60 days of rejection, whichever is later.

E. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 12 months of the date on which eligibility was determined.

Effective immediately, the MA Program will accept all claims received within 12 months with date of service, date of discharge, or month of service of March 1, 2008 forward. The MA Program will be able to process these claims as timely if received within 12 months of date of service or discharge or month of service. These claims can be processed electronically or by paper. All other billing requirements remain the same.

If you need additional information regarding this transmittal, please contact Provider Relations at 410-767-5503 (professional) or 410-767-5457 (institutional and long term care).