10A NCAC 22B .0104 is proposed for readoption without substantive change as follows:

10A NCAC 22B .0104 TIME LIMITATION

(a) To receive payment, claims shall ~~must~~ be filed either:

(1) within ~~Within~~ 365 days of the date of service for services other than inpatient hospital, home health or nursing home services; ~~or~~

(2) within ~~Within~~ 365 days of the date of discharge for inpatient hospital services and the last date of service in the month for home health and nursing home services not to exceed the limitations as specified in 42 C.F.R. 447.45, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; ~~447.45;~~ or

(3) within ~~Within~~ 180 days of the Medicare or other third party payment, or within 180 days of final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Paragraph, ~~Rule,~~ if it may ~~can~~ be shown that:

(A) a ~~A~~ claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Paragraph; ~~Rule; and~~

(B) there ~~There~~ was a possibility of receiving payment from the third party payor with whom the claim was filed; and

(C) good faith ~~Bona fide and timely~~ efforts were pursued to achieve either payment or final denial of the third-party claim.

(b) Providers shall ~~must~~ file requests for payment adjustments or requests for reconsideration of a denied claim no later than 18 months after the date of payment or denial of a claim.

(c) The time limitation specified in Paragraph (a) of this Rule may be waived by the Division of Medical Assistance when a correction of an administrative error in determining eligibility, application of court order or hearing decision grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

(d) In cases where claims or adjustments were not filed within the time limitations specified in Paragraphs (a) and (b) of this Rule, and the provider shows good cause for the failure to do so, ~~so was beyond his control, he~~ the provider may request a reconsideration review by the Director of the Division of Medical Assistance. "Good cause" is an action uncontrollable by the provider. The Director of Medical Assistance shall be ~~is~~ the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing a petition for a contested case hearing in conformance with G.S. 150B-23.

History Note: *Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 447.45;*
Eff. February 1, 1976;
Amended Eff. October 1, 1977;
Readopted Eff. October 31, 1977;

Amended Eff. June 1, 1993; June 1, 1988; November 1, 1986; July 1, 1985; ~~1985.~~

Readopted Eff. May 1, 2018.