Title of Rule: Revision to the Medical Assistance Act Rule concerning Timely Filing, Section 8.043
Rule Number: MSB 25-07-28-A
Division / Contact / Phone: Medicaid Operations / Scott Lindblom / scott.lindblom@state.co.us

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The timely filing limit in 10 CCR 2505-10-8.043 should be updated from 120 days to 365 days to reflect the Department's current policy.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain: This emergency rulemaking is necessary to align regulatory language with the Department's practice of allowing a 365-day timely filing limit for providers to submit claims for payment. Maintaining the outdated 120-day limit in rule creates a conflict that could confuse providers and trigger state or federal audit findings. Such findings could result in a disallowance of federal funds and expose the Department to financial and compliance risks. Prompt correction through emergency rulemaking is essential to ensure consistency, maintain program integrity, and uphold compliance with federal and state requirements.

3. Federal authority for the Rule, if any:

   42 C.F.R. § 447.45, Timely claims payment.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S.

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The primary class of persons affected by the proposed rule are Medicaid providers who submit claims for reimbursement to the Department. These providers will benefit from the rule change, as it ensures the regulation reflects the current 365-day timely filing limit already in practice, thereby providing greater clarity and consistency. Aligning the rule with current operations also helps avoid unnecessary administrative appeals to the Office of Administrative Courts. No classes of persons are expected to bear any new costs as a result of this change.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   There are no new or increased costs to providers or other stakeholders as this rule change formalizes a long-standing policy. Qualitatively, this alignment supports operational clarity and minimizes provider confusion, ensuring consistency between regulation, Department guidance, and MMIS functionality.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no additional costs to the Department or other state agencies, as the Medicaid Management Information System (MMIS) has been operating with the 365-day timely filing limit since shortly after its implementation. The proposed rule does not require any system changes or additional enforcement resources. The rule will also have no impact on state revenues.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The benefits of the proposed rule include regulatory consistency, reduced audit risk, and improved transparency for providers. In contrast, inaction could lead to future audit findings from oversight entities such as the Office

of the State Auditor (OSA) or the federal Payment Error Rate Measurement (PERM) program. These findings could result in financial disallowances or penalties, including potential recoupment of federal funds. Therefore, the benefits of aligning the regulation far outweigh the risks and costs of maintaining the outdated 120-day limit.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the purpose of this rule change. The amendment is simple and directly updates the regulation to match the Department's operational practice.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Given the straightforward nature of the change (extending the timely filing limit from 120 days to 365 days to reflect current practice) no alternative methods were considered. Codifying the existing policy in regulation is the most direct and effective approach to mitigate audit risk and provide clear guidance to providers.

8.043 TIMELY FILING REQUIREMENTS

.01 ~~Effective 10/1/93, all~~ All claims for services provided to eligible Medicaid recipients must be received by the fiscal agent within ~~120~~ 365 days from the date of service or 120 days from the Medicare processing date for all Medicare Crossover claims.

.02 Timely Filing Extensions for Circumstances Beyond the Control of the Provider

A. Delayed Processing by Third Party Resources

Medicaid is always the payer of last resort; however, if the initial timely filing period expires because of delays by the third party insurer in providing third party payment or denial documentation, the claim will be considered timely if it is received within 60 days from the date of the third party payment or denial or within 365 days from the date of service, whichever occurs first. A copy of the third party payment voucher or letter of denial must be attached to the claim form or the claim will be denied.

B. Delayed/Retroactive Recipient Eligibility

If the initial timely filing period expires because of delays by the county in establishing recipient eligibility or because recipient eligibility is back-dated, the claim will be considered timely; if it is received within the applicable initial timely filing period from the date that the recipient appears on the state eligibility files. Each claim must be accompanied by an authorized notification from the county department of social services which verifies the delayed or retroactiave eligibility, and states the date when such action was entered on the eligibility system or the claim will be denied.

C. In all other instances, including possible exceptions to 8.043.02, A. and B. above, and 8.043.03 following, where extenuating circumstances beyond the provider's control allegedly existed, such circumstances as might have existed must be thoroughly documented and submitted as a reconsideration to the fiscal agent's Medicaid Exceptions Unit. However, employee negligence in carrying out their duties or employer negligence in making sufficient and well-trained employees available or in properly monitoring contractual employees/agents will not be considered extenuating circumstances beyond the control of the provider.

.03 Rebills/Adjustments/Reconsiderations

Denied and incorrectly paid claims may be resubmitted to the fiscal agent at any time during the initial timely filing period. However, if the initial timely filing period has expired, the fiscal agent must receive the rebill or adjustment/reconsideration request within 60 days from the latest Remittance Statement (RS) run date or the latest other written notification of adverse action. Copies of all Medicaid Remittance Statements and/or other written notifications of adverse action documenting initial and subsequent timely filing within the 60-day limit must be attached to the claim form or the rebill or request for adjustment/reconsideration will be denied.

.04 All original claims, rebills of denied claims, requests for adjustment of incorrectly paid claims, or requests for reconsideration of denied or incorrectly paid claims to the fiscal agent's Medicaid Exceptions Unit must be received by the fiscal agent within the applicable timely filing period; and, it is the provider's responsibility to ensure that this receipt occurs.

A claim, whether filed for the first time, rebilled, or submitted for adjustment/reconsideration, is considered to be filed when the fiscal agent documents receipt of that claim. Dated claim

signatures, certified mail receipts and postmarks, or internal office logs (computerized or manual), for example, shall not constitute filing for the purpose of meeting the timely filing requirements of this manual and the controlling federal regulations. The date of receipt is the date the fiscal agent receives the claim, as indicated by a date stamp, or an imprinted Transaction Control Number assigned by the automated claims processing system - on the claim.

If an original claim, a rebill of a denied claim, a request for adjustment of an incorrectly paid claim, or a request for reconsideration of a denied or incorrectly paid claim to the fiscal agent's Medicaid Exceptions Unit is not acknowledged in written/printed form within thirty (30) days, it is the responsibility of the provider to inquire concerning its status, or resubmit. The weekly Medicaid Remittance Statement shall be proper and sufficient notification of fiscal agent action resulting from any provider request or submittal.

.05 All valid claims must be paid within 12 months from the date of receipt, except in the following circumstances:

A. This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system; that is, claims that are paid on the basis of a provisional payment rate set prospectively for an accounting period, and in which payments may be retrospectively adjusted on the basis of the cost experience during the accounting period.

B. If a claim for payment under Medicare has been filed in a timely manner, payment may be made for a Medicaid claim relating to the same services within 6 months of notice of the disposition of the Medicare claim.

C. The time limitation does not apply to claims from providers under investigation for fraud or abuse.

D. Payment may be made at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it, including the resolution of an administrative reconsideration or appeal.