

1 10A NCAC 22B .0104 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2
3 **10A NCAC 22B .0104 TIME LIMITATION**

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

- 5 (1) ~~within Within~~ 365 days of the date of service for services other than inpatient hospital, home health
6 or nursing home services; ~~or~~
- 7 (2) ~~within Within~~ 365 days of the date of discharge for inpatient hospital services and the last date of
8 service in the month for home health and nursing home services not to exceed the limitations as
9 specified in 42 C.F.R. 447.45, which is adopted and incorporated by reference with subsequent
10 changes or amendments and available free of charge at <https://www.ecfr.gov/>; 447.45; or
- 11 (3) ~~within Within~~ 180 days of the Medicare or other third party payment, or within 180 days of final
12 denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs
13 (1) or (2) of this Paragraph, Rule, if it ~~is~~ [may] ~~can be~~ shown that:
- 14 (A) ~~a A~~ claim was filed with a prospective third-party payor within the filing limits in
15 Subparagraph (1) or (2) of this Paragraph, Rule; ~~and~~
- 16 (B) ~~there There~~ was a possibility of receiving payment from the third party payor with whom
17 the claim was filed; and
- 18 (C) good faith ~~Bona fide and timely~~ efforts were pursued to achieve either payment or final
19 denial of the third-party claim.

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

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

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

33
34 *History Note:* Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 447.45;
35 Eff. February 1, 1976;
36 Amended Eff. October 1, 1977;
37 Readopted Eff. October 31, 1977;

1
2
3

Amended Eff. June 1, 1993; June 1, 1988; November 1, 1986; July 1, 1985; ~~1985~~.
Readopted Eff. July 1, 2018.