Timely Filing Limitation Billing Policy Effective January 1, 2017

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

Agenda

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Timely Filing Limitation Billing Policy

MSA 16-37

MSA 17-44

Timely Filing Limits Billing Policy

- Each claim received and acknowledged by the MDHHS CHAMPS claims processing system receives a unique identifier called a Transaction Control Number (TCN). The TCN is found on the Remittance Advice (RA) and in CHAMPS.
- The Composition of the TCN is designed to reflect the date the claim was received (plus other elements). Position 3-4 = last 2 digits of the service year. Position 5-7 = Julian date.
- Example: 31170301000222l000 = January 30th 2017

  3116365l000222l000 = December 30th 2016 (Leap Year)

Timely Filing Limits Billing Policy (cont.)

- Per MSA 16-37: Effective January 1, 2017, claims must be received and acknowledged by MDHHS within 12 months from the date of service (DOS).
- For Institutional invoices, this will be calculated using the Claim Header “To/Through” DOS reported.
- For professional and dental invoices, this will be calculated using the service line level “From” DOS.
- Claims for dates of service prior to January 1, 2017, that have been kept appropriately active, must be submitted no later than December 31, 2017.

Timely Filing Limits Billing Policy (cont.)

- Claims exceeding the new timely filing limits (over 1 year from the DOS) will be denied unless the claim meets exception(s) criteria.
  - Note: Claim notes/remarks/comments explaining the request for the exception are required.
- Claims rejected for Timely Filing Billing Limitation will reflect the Claim Adjustment Reason Code 29.
- **If DOS is on or after January 1, 2017:**
  - Rebilling claim denials every 120 days will no longer be required as this policy eliminates “continuous active review”.

Timely Filing Limits Billing Policy (cont.)

- **For DOS prior to January 1, 2017:**
  - Policy in effect included “continuous active review” which was defined by: To meet timely filing criteria the claim must be received and acknowledged within 12 months from the DOS and additionally must be billed within 120 days from the date of the last rejection.
  - Documentation of prior activity is always the responsibility of the provider.
  - New policy states that any claim or claim adjustments must be submitted within 1 year from the DOS and must be kept active every 120 days and will need to be resolved prior to December 31, 2017.
  - If not resolved by December 31, 2017, the claim will be denied.

Timely Filing Limits Billing Policy (cont.)

- Voids:
  - Medicaid allows timely filing limits to be bypassed when returning an overpayment. Void logic bypasses timely filing editing.
- Claim adjustments billing for late or additional charges:
  - For services rendered on or after January 1, 2017, must be submitted within twelve calendar months from the DOS.
  - As a reminder all claim void or adjustments require notes/remarks/comments that clearly explain why the money is being returned.

Exceptions to Timely Filing Limits

Exceptions

- Per the Michigan Medicaid Provider Manual (MPM), *Chapter* General Information for Providers, *Section* 12.3 Billing Limitation, exceptions may be made in the following circumstances:
  - Departmental administrative error occurred that can be documented.
  - An incorrect prior authorization, incorrect PACER, incorrect level of care or other restriction in the system. Required claim note “Documentation of administrative error submitted to DMP.”
  - Medicaid beneficiary eligibility/authorization was established retroactively for more than 12 months after the DOS.
  - Judicial action/mandate.
  - Medicare and or other primary coverage processing was delayed.

Exceptions (cont.)

- Provider returning overpayment with claim notes “Returning Money” (via claim replacement or void).

- Primary insurance taking back payment after timely filing billing limitation has passed.

- Predictive Modeling:

If a claim submission is delayed due to a previously submitted claim being in review for predictive modeling. Then the claim note needs to say “Delayed due to Predictive Modeling TCN XXXXXXXXXXXXXXXXXX (TCN of previously denied/paid claim)

Exceptions (cont.)

- The re-submission must be received within 120 days from the remittance date of the previous denied/paid claim.
- Retroactive Medicaid Eligibility/Authorization claims will be accepted up to six months after the retroactive eligibility determination date. The claim note must say “Timely Filing” for consideration.
- NOTE: Retroactive provider enrollment is not considered an exception to the billing limitation.

Billing Instructions

Billing Instructions

- For claims meeting exceptions; Departmental administrative error has occurred or Medicaid beneficiary eligibility/authorization was established retroactively, the provider must contact the local MDHHS county office to initiate the following exception process:
  - The MDHHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038).
  - The provider can access the MSA-1038 status tool at www.mihealth.org to determine approval or denial of the MSA-1038 request.
    - Denials of the MSA-1038 exception must be resolved at the local county level.
  - Once approved the provider prepares the claim(s) related to the exception. It is required that the claim includes a remark/note/comment “MSA-1038 on file”.
  - The provider submits the clean claim to MDHHS CHAMPS through the normal submission process.

Billing Instructions (cont.)

- Claims meeting any of the other exceptions are to be submitted as usual through CHAMPS with appropriate notes/remarks/comments and evidence justifying the exception request, such as:
  - A copy of the Court order.
  - Claims previously billed in error under a different provider National Provider Identifier (NPI) number
    - Note: The TCN(s) must be reported.
  - Claims previously billed erroneously under a different beneficiary ID number
    - Note: The TCN(s) must be reported.
  - Claims previously billed using a different “statement covers period” for nursing facilities and inpatient hospitals
    - Note: The TCN(s) must be reported.

Billing Instructions (cont.)

- Medicare or other primary insurance exceptions:
  - The claim must be submitted within 120 days of the Medicare/primary insurance remit date in order to be considered for reimbursement.
  - Suggested notes/remarks/comments on claim: Paymt taken back by Primary Ins. On MM/DD/YYYY due to retro elig change.
  - Claims will be accepted up to six months after the retroactive eligibility determination date. The claim note must say “Timely Filing” for consideration. This is only for date of service Jan. 01, 2017 and ongoing.

Billing Instructions (cont.)

- Third Party Liability (TPL) Recovery (VOID):
  - Provider needs to re-bill the claim.
  - Must be submitted within 120 days from the TPL recovery.
  - When DOS is more then one year old, rebill to CHAMPS on a new clean invoice (do not use claim replacement bill type).
  - Suggested notes/remarks/comments on the claim: TPL take-back on TCN xxx (state the take back TCN in its entirety) on pay-cycle date MM/DD/YYYY.
- All documentation for exceptions should be submitted through the Document Management Portal (DMP).
- Claims or claim adjustments submitted later than one calendar year from the DOS without notes/remarks/comments will be automatically denied.

Billing Instructions (cont.)

- If Medicaid Fee-For-Service (FFS) voids a claim due to a Medicaid beneficiary being in a Medicaid Health Plan (MHP) eligibility, claims must be submitted to the MHP within 60 days from the FFS credited RA date.
- A Biller B Aware message may be posted to notify providers of the take backs.
  - For further billing instructions or issues, providers will need to contact the appropriate MHP.

Reasons for Change

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- Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Social Security Act, as well as the Medicare regulations at 42 CFR §424.44, specify the time limits for filing Medicare FFS (Part A and Part B) claims.
- Section 6404 of the Affordable Care Act reduced the maximum period for submissions of all Medicare FFS claims to no more than 12 months (one calendar year) after the DOS were furnished.
- To eliminate administrative difficulties to both the provider and to the State of Michigan there will no longer be the need for “continuous active review”; as there will be a true drop dead date for every account.
- This new policy will increase departmental efficiency and provider accountability.

Policy Reminder

Responsibilities as a MDHHS Health Care Enrolled Provider

Policy Reminder

- The Michigan Medicaid Provider Manual (MPM), *Chapter* General Information for Providers, *Section* 11- Billing Beneficiaries states that when a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for services for which the provider has been denied payment because of improper billing.

Provider Resources

- **MDHHS website:** www.michigan.gov/medicaidproviders

- **We continue to update our Provider Resources, just click on the links below:**
  - Listserv Instructions
  - Medicaid Updates
  - Update Other Insurance NOW!
  - Medicaid Provider Training Sessions
  - Timely Filing Provider Tip

- **Provider Support:**
  - ProviderSupport@michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program