IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201829 JUNE 19, 2018

IHCP to implement 180-day timely filing limit for FFS claims effective January 1, 2019

Effective January 1, 2019, the Indiana Health Coverage Programs (IHCP) will revise the timely filing limit on claims for services rendered through the fee-for-service (FFS) delivery system to 180 calendar days from the date of service (DOS). The 180-day timely filing limit will apply to claims with DOS on or after January 1, 2019. For inpatient claims, the 180-day limit will be based on the member's date of discharge. The current 1-year timely filing limit will continue to apply to claims with DOS or dates of discharge on or before December 31, 2018.

The circumstances excluded from the timely filing limit will remain unchanged:

- **Crossover claims** – Medicare or Medicare Replacement Plan primary claims containing paid services (including services that paid at zero, due to deductibles) are not subject to the 180-day timely filing limit. ***Note: If Medicare or a Medicare Replacement Plan denies a claim, the 180-day limitation applies to the Medicaid claim.***
- **Overpayment adjustment requests** – These requests are not subject to the 180-day timely filing limit. Any overpayment identified by a provider must be returned to the IHCP, regardless of the 180-day filing limit. The overpayment adjustment must be submitted with an explanation attached to justify partial recoupment; otherwise, the claim will be processed and recouped in its entirety.

The reasons for **extending** the timely filing limit (beyond the 180 days) will remain unchanged:

- If a member's eligibility is effective retroactively, the timely filing limit is *extended to 180 days from the date eligibility was established.* Documentation must be submitted with the claim identifying retroactive eligibility.
- If prior authorization (PA) for a service is approved retroactively, the timely filing limit is *extended to 180 days from the date the PA was approved*. A copy of the approved PA stating "retroactive prior authorization" must be included as an attachment to the claim.
- If an IHCP policy change is effective retroactively, the timely filing limit is *extended to 180 days from the date of publication of the policy change*. A copy of the publication must be included as an attachment to the claim.
- For waiver providers, proof that a plan of care was issued late or copies of the review findings letter from an audit must be submitted.
- If third-party payer notification is delayed, the timely filing limit is *extended to 180 days from the date on the explanation of benefits (EOB) from a primary payer.* A copy of the primary payer's EOB must be included as an attachment to the claim.

The circumstances under which the timely filing limit **might be waived** with proper documentation will remain unchanged:

- Lack of timely filing is due to an error or action by DXC Technology, OptumRx, or the State – The claim must be submitted with documentation that clearly identifies the error or action that delayed proper adjudication of the claim.
- Reasonable and continuous unsuccessful attempts by the provider to receive payment from a third party, such as Medicare or another insurance carrier – The claim must be submitted with documentation that clearly identifies multiple filing attempts in a timely manner along with all responses from the payer or third party.
- Reasonable and continuous unsuccessful attempts by the provider to resolve a claim problem – The claim must be submitted with documentation that clearly identifies multiple filing attempts to **correct and resolve** claim problems in a timely manner along with all responses. Resubmitting the claim without any corrections does not constitute a filing attempt.

The definitions of initial claim, corrected claim/claim detail, duplicate claim, and claim adjustment (void/replacement) will remain as currently published in the *Claim Submission and Processing* and *Claim Adjustments* provider reference modules, except that the timely filing limit will be 180 days rather than 365 days. Billing guidance, including the accepted methods of claim submissions, will remain unchanged by the revised timely filing limit. The expectation of "*reasonable and continuous attempts to resolve a claim problem*" on the part of providers, as well as processes and time frames associated with claim adjustments and the submission of written requests for the administrative review and the appeal of claim adjudications, will remain unchanged, as outlined in the *Claim Administrative Review and Appeal* provider reference module. Provider reference documents can be found on the IHCP provider website at indianamedicaid.com.

Timely filing limits associated with managed care claims for Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members are established and published by the managed care entities (MCEs). Related questions should be directed to the appropriate MCE.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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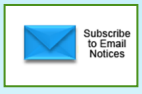

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