IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201561 SEPTEMBER 1, 2015

IHCP clarifies policy regarding the timely filing of claims

The Indiana Health Coverage Programs (IHCP) reminds providers that for reimbursement consideration, initial fee-for-service (FFS) claims must be filed within one year from the date services are rendered. This policy is compliant with the provisions set forth in Indiana Administrative Code (IAC) *405 IAC 1-1-3*. Claims that do not comply with the one-year timely filing limit will deny for explanation of benefits (EOB) code 512 – *Your claim was filed past the timely filing limit without acceptable documentation.*

Timely filing limit exceptions

There are instances where the one-year from the date of service (DOS) timely filing limit does not apply or where IHCP policy may extend or waive the limit if the proper supporting documentation is submitted with the claim.

- The one-year timely filing limit **is not applicable** in the following circumstances:
  - **Medicare crossover claims:** Medicare primary claims containing paid services are not subject to the one-year timely filing limit.
  - **Overpayment adjustment requests:** These requests are not subject to the one-year timely filing limit. Any overpayment identified by a provider must be returned to the IHCP regardless of the one-year 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 one-year timely filing limit **is extended** in the following circumstances:
  - If a member's eligibility is effective retroactively, the timely filing limit is *extended to one year 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 one year 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 one year from the date of publication of the policy change*. A copy of the publication must be included as an attachment to the claim.
  - If third-party payer notification is delayed, the timely filing limit is *extended to one year from the date on the EOB from a primary payer.* A copy of the primary payer's EOB must be included as an attachment to the claim.

- The one-year timely filing limit **will be waived** if justification is provided to substantiate the following circumstances:
  - Lack of timely filing is due to an error or action by HP, OptumRX, the State, or County – 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.

Claim resubmissions, adjustments, and requests for administrative review

If an initial claim **is filed timely and is denied**, the provider has the following options:

- If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections. For adjudication purposes, a denied claim that is resubmitted *with corrected information* is considered to be an *initial* claim and as such is subject to the one-year timely filing limit. For adjudication purposes, a denied claim resubmitted *without corrected information*, is considered to be a *duplicate* claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the one-year timely filing limit and will not be accepted as "*reasonable and continuous attempts to resolve a claim problem*" for consideration to waive or extend the timely filing limit.
- If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider may submit a written request for an administrative review stating why the provider disagrees with the claim denial. The written request for administrative review must be filed within 60 days of notification of the claim's disposition. The date of notification is considered to be the date on the Remittance Advice (RA).

Note: The practice of extending the timely filing limit by repeatedly refiling the same claim with no corrections or documented attempts to resolve the claim is incompatible with the intent of the IAC. Effective immediately, this practice is no longer acceptable.

If an initial claim **is filed timely and is paid**, including claims partially paid, or paid at zero, the provider has the following options:

- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a *claim adjustment* via paper or a *claim void/replacement* electronically with corrections. The claim adjustment or claim void/replacement must be filed within 60 days of notification of the claim's disposition. The date of notification is considered to be the date on the RA.
- If a claim payment disagreement is not due to a provider's error, the provider may submit a written request for administrative review stating why the provider disagrees with the claim payment amount. The written request for administrative review must be filed within 60 days of notification of the claim's disposition. The date of notification is considered to be the date on the RA.

- Denied claims are not eligible for adjustment or void and replacement processes. See previous section for procedures for denied claims.

Claim filing procedures

All claims must be filed, resubmitted, adjusted, or replaced using the regular submission methods and the appropriate addresses. See the *IHCP Quick Reference Guide* at indianamedicaid.com for the most current filing information. As a rule, Written Correspondence staff, Customer Assistance representatives, and Provider Relations field consultants will no longer be able to file claims on a provider's behalf. Claims mailed to addresses other than those noted in the *IHCP Quick Reference Guide* will be returned to the provider for filing through normal channels. Any resulting processing delays could negatively affect compliance with timely filing limits.

Claims-related inquiries regarding covered services, benefit packages, denial explanations, policy clarifications, claims completion guidance, or other general filing questions are appropriately referred to the Customer Assistance Call Center, your Provider Relations field consultant, or to Written Correspondence. Written inquiries should be submitted on the *IHCP Written Inquiry* form located on the *Forms* page at indianamedicaid.com.

Administrative review

Before filing a request for administrative review, a provider must exhaust all routine measures to correct a claim. Routine measures include:

- Reviewing the RA
- Making any applicable corrections identified by the adjustment reason codes (ARCs), remark codes, or EOB codes
- Resubmitting a corrected claim (denied claims), submitting a claim adjustment via paper, or submitting a claim void/ replacement electronically

After the provider has made reasonable attempts to correct or adjust a claim, if the provider remains dissatisfied with the claim denial or payment amount, the provider may submit a request for administrative review. Requests must be submitted in writing within 60 calendar days of the date of notification of payment or denial. The date of notification is considered to be the date on the RA relaying the disposition of the claim.

To file a request, providers should complete the new *IHCP Administrative Review Request* form. A copy of this form is provided as an attachment to this bulletin for your reference and can be found on the *Forms* page at indianamedicaid.com. Be sure to complete all applicable fields, check the appropriate "Administrative Review Request" reason field, and submit all relevant documentation including operative reports, Remittance Advice statements, insurer EOBs, and so forth. Mail the completed form and all documentation to:

HP Written Correspondence
Administrative Review
PO Box 7263
Indianapolis, IN 46207-7263

Providers will receive a written confirmation within 10 business days of receipt of their request and will receive a written determination within 90 business days of receipt. If the determination from the administrative review is unfavorable, the provider may file an appeal.

National Correct Coding Institute (NCCI) claim disputes: If a provider believes a claim has been coded correctly and would like to have the NCCI denial (EOBs 4181-4197) reconsidered, the provider must file a request for administrative review clearly identifying the reason for the dispute. Before filing the request, providers are encouraged to review the pertinent NCCI Column I and Column II code pairs and Medicaid Unlikely Edits (MUEs), which can be found on The National Correct Coding Initiative in Medicaid page at medicaid.gov. The site does not display well using some versions of Internet Explorer; providers might consider using an alternate web browser such as Mozilla Firefox or Google Chrome.

Appeals

Before filing an appeal, the provider must exhaust all other administrative remedies, as outlined previously, including an administrative review. If the provider is not satisfied with the results of the administrative review, the provider can appeal under the provisions of *405 IAC 1-1.5*. To do so, the provider must file a written request of appeal with the Indiana Family and Social Services Administration (FSSA).

The appeal request should include all pertinent facts, proof of actions taken to resolve the payment or denial, and any associated documentation. This information must be delivered to the following address within 15 business days of the adverse administrative review determination:

Secretary,
Indiana Family and Social Services Administration
c/o Office of Medicaid Policy and Planning MS07
402 W. Washington Street, W382
Indianapolis, IN 46204-2739

If a provider elects to appeal, the provider must also file a statement of issues within 45 days of the date of the adverse administrative review determination. The statement of issues should be sent to the same address as the appeal request and should conform to *405 IAC 1-1.5-2(d)* and *IC 4-21.5-3*. Appeal proceedings will be conducted by an FSSA-appointed administrative law judge.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.

INDIANA HEALTH COVERAGE PROGRAMS
ADMINISTRATIVE REVIEW REQUEST

Date		For HP Internal Use Only – LCN	

Provider name:		NPI/LPI	
Contact name:		Telephone number/ Email address	

REASON FOR ADMINISTRATIVE REVIEW REQUEST (please mark applicable box below)

	Request reconsideration of claim payment or denial
	Request review of NCCI denial
	Request review of assistant surgeon modifier AS denial (include operation report)

Claim Information (include all previous filing/adjustment attempts)

Member name		Member number (RID)	
Date of service		Billed amount	
Date paid/denied		ICN	
Date paid/denied		ICN	
Date paid/denied		ICN	

Please provide a detailed description of the reason for your request (attach all pertinent documentation including Remittance Advice statements, insurer EOB, medical records, and so on):

Retain a copy for your records and mail original to:

HP Written Correspondence
PO Box 7263
Indianapolis, IN 46207-7263

Reviewed/Updated: September 2015