Section 11: Claim Filing Limitations

Providers must submit all claims for services rendered within one year of the date of service. See the *Indiana Administrative Code 405 IAC 1-1-3* for the complete rule narrative about filing limitations.

All claims must be filed, resubmitted, adjusted, or replaced using the regular submission methods and the appropriate addresses. The *IHCP Quick Reference Guide* at indianamedicaid.com contains the most current claim filing addresses. As a rule, Written Correspondence staff, Customer Assistance representatives, and Provider Relations field consultants do not 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, unless otherwise instructed. Any resulting processing delays could negatively affect compliance with timely filing limits.

In some instances, claims filed beyond the one-year filing limit can be considered for reimbursement if the proper supporting documentation is submitted with the claim. It is important to note that each claim stands on its own merit, which means that each claim must have a set of supporting documentation attached. Submitting multiple claims with only one set of documentation is not acceptable.

Timely Filing Limit Exceptions

When Timely Filing Limit Is Not Applicable

The one-year timely filing limit **is not applicable** in the following circumstances:

- **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 one-year timely filing limit.

Note:	*If Medicare or a Medicare Replacement Plan denies a claim, the one-year limitation applies to the Medicaid claim.*

- **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 Indiana Health Coverage Programs (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.

When Timely Filing Limit Is Extended

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.

- 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 one year 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.

When Extenuating Circumstances Are Considered for Waiving the Timely Filing Limit

For the situations listed in this section, the Family and Social Services Administration (FSSA) will review and determine if the documentation substantiates override of timely filing. These situations will be considered on an individual basis. 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 DXC, 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.

> *Note: If a third-party payer fails to respond, the provider must indicate **"90 Days No Response"** on an attachment. Detailed information for submission using the 90-Day Provision is located in the Third Party Liability module.*

- 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.

How to Submit Claims for Filing Limit Waiver Requests

The following documents may be included in documentation showing that reasonable and continuous attempts have been made to correct and resolve claim problems:

- Remittance Advice (RA) statements
- 277 Claim Inquiry response transaction from the 276 Claim Inquiry transaction
- Claim screen print from Provider Healthcare Portal (Portal)
- Answered inquiries (submitted via mail or Portal secure correspondence) from the Written Correspondence Unit
- Dated EOBs from third-party payers
- IHCP-generated documentation of prior claim submission
- Letters from the local county office
- Letters from other insurance carriers
- Returned PA requests; a chronological narrative is also helpful

> *Note: The timely filing limitation cannot be waived without documentation; claims without the acceptable documentation will automatically deny for timely filing.* ***Provider-generated notes or claims filing time lines are not acceptable documentation.***

Paper attachments should follow these guidelines:

- Legible and signed paper claims; photocopies acceptable
- Required supporting documentation; photocopies acceptable
- Documentation attached in chronological order; a chronological narrative is also helpful
- Individual documentation trail attached to each claim
- Correct address for claim attachments

> ***Note: For providers using copies of claims for attachments****: The CMS-1500 and UB-04 claim forms contain a bar code at the top of the claim form. The bar code indicates a new claim, and thus a new sequence number, to the scanner in the mailroom. When sending copies of claims as attachments, the provider must place a large* ***X*** *through the claim copy to indicate to the processor that the claim copy is being used for filing-limit documentation. Dental providers must also place a large* ***X*** *through the claim copy as indicated above.*

Situations That Will Be Reviewed on an Individual Basis by the FSSA

The following circumstances will be reviewed on an individual basis by the FSSA to determine if good faith efforts were made to prevent retroactive enrollment or submit claims in a timely manner:

- A member who is not eligible for the IHCP sees a provider that is not an IHCP provider. If the member is retroactively enrolled, the provider may also be retroactively enrolled and allowed to bill for services rendered.
- The provider is unaware that the patient was eligible for Medicaid at the time services were rendered. The following conditions must be met:
  - The provider's records document that the patient refused or was physically unable to provide his or her Medicaid number.
  - The provider can substantiate that reimbursement was continually pursued from the patient until Medicaid eligibility was discovered.
  - The provider billed the IHCP or otherwise contacted the IHCP in writing regarding the situation within 60 days of the date Medicaid eligibility was discovered [see *405 IAC 1-1-3(c)*].
- A member receives a service by an out-of-state provider that was not enrolled with the IHCP at the time services were rendered. Such situations will be reviewed on an individual basis by the FSSA to ascertain if the provider made a good-faith effort to enroll and submit claims in a timely manner.

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 RA.

If a line item on a claim is denied, that line item should be resubmitted separately, unless the claim details are dependent of one another for payment. For example; all surgical services for the same member, same date, and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.

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.

See the *Claim Adjustments* module and the *Claim Administrative Review and Appeals* module for detailed information.