Timely Filing Policy Tip

Claim Adjustment Reason Code 29

Policy: Medicaid Provider Manual (MPM) Chapter "General Information for Providers" Section

11.3 Billing Limitations. Policy change per MSA 16-37 effective 1/01/2017.

Claims are due within 12 months from the date of service (DOS). Each claim received by MDHHS receives a Transaction Control Number (TCN) that indicates the date the claim was entered into CHAMPS. The TCN is used when determining the active review of a claim. For claims using the institutional format and MHPs, it is the "To" or "Through" date indicated on the claim. For all other providers, it is the date the service was rendered or delivered. Claims over one year old will only be considered if the reason for filing the claim late is due to one of the policy exceptions and the exception is properly documented. Claim replacements billing for late or additional charges must be filed within 12 months from the date of service. Claim adjustments require comments/notes/remarks.

All claims for services rendered prior to 1/01/2017 and have been kept active according to prior timely filing policy will be allowed to be considered if kept active every 120 days from the latest rejection. In all cases, claims must be submitted no later than 12/31/2017.

It is the provider's responsibility to maintain appropriate records to prove timely filing and to provide documentation when required. Providers filing for an exception should review the current MPM for the exception criteria. A claim comment/note/remark is required.

I. **Administrative Error MSA-1038**
    - The MSA 1038 exception is a manual process, it is not automated - claims will still suspend for manual review. Due to audit requirements, it is required that the provider note within the claim if they are requesting an exception to the time limit and must only be asked for if the MSA 1038 approval date segment covers all of the dates of service of the account.
    - A provider can access the MSA-1038 tool to verify if there is an exception on file for the date of service.
    - MSA-1038 status tool: Search by Member ID or Name/DOB to determine the status of a submitted MSA-1038.

    Required claim note: ***MSA-1038 on file.***

II. **Third Party Liability (TPL) Recovery (VOID)-Provider needs to re-bill**
    - When a date of service is more than one year old, rebill to CHAMPS on a new clean invoice (do not use claim replacement bill type).
    - Re-bill within 120 days from the TPL take-back pay-cycle date.

    Required claim note: ***TPL take-back on TCN xxx (state the take-back TCN in its entirety) on pay-cycle date MM/DD/YYYY.***

- The claim note is 67 characters- only the first 80 characters of notes/comments are received on a claim.

III. **Retroactively dis-enrolled from a Medicaid Health Plan (MHP)-Provider needs to re-bill to Fee for Service (FFS)**
   - Upload the take-back EOB in the [DMP](#)
   - Re-bill a new claim within 120 days from the MHP take-back.

     Required claim note: ***MHP Take Back EOB in DMP***

IV. **Medicare/Private/Group insurance adjusts payment-Provider needs to re-bill**
   - When insurances change coverage parameters retroactively and take back or adjust their payments, rebill CHAMPS on a new clean invoice (if there were no previous FFS claims paid for this account) or via claim adjustment within 120 days of the takeback.
   - Upload the take-back EOB in the [DMP](#)

     Required claim note: ***Take back by Primary Ins. EOB in DMP***

V. **The MDHHS administrative error has occurred that may be documented**
   - When an error is made by MDHHS, or one of its contractors, such as incorrect prior authorization, incorrect PACER, incorrect level of care, or other restrictions in the system.
   - Appropriate written proof of such error must be uploaded to DMP prior to filing the claim.

     Required claim note: ***Documentation of administrative error submitted to DMP***

VI. **Predictive Modeling**
   - If a claim submission is delayed due to a previously submitted claim being in review for predictive modeling.
   - The re-submission must be received within 120 days from the remittance date of the previously denied/paid claim.

     Required claim note: ***Delayed due to Predictive Modeling TCN XXXXXXXXXXXXXXXXX (TCN of previously denied/paid claim)***

VII. **Retroactive Medicaid Eligibility/Authorization**
   - Claims will be accepted up to six months after the retroactive eligibility determination date.

     Required claim note: ***Timely Filing for consideration***