PROVIDER RELATIONS
Michigan Department of Health and Human Services

Billing Tips –Timely Filing

Claim Adjustment Reasons Code 29

Policy: Medicaid Provider Manual (MPM) Chapter "General Information for Providers" Section 12.3 Billing Limitations.

First claim is due within 12 months from the date of service (DOS). Claims over one year old must have continuous active review. Active review means the claim was received and acknowledged by Michigan Department of Health and Human Services (MDHHS). Each claim received by MDHHS receives a Transaction Control Number (TCN) indicating the date the claim was entered into CHAMPS. The TCN is used when determining active review of a claim. Claims over one year old must be billed within 120 days from the date of the last rejection. Claim replacements must be filed within 12 months of the latest remittance advice (RA) date.

It is the provider's responsibility to maintain activity 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 note is required.

Administrative Error MSA-1038:

- The MSA 1038 exception is a manual process, it is not automated. Claims will suspend for manual review. Due to audit requirements, it is required that the provider add a note within the claim by the provider to request an exception to the time limit.
- 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 status of a submitted MSA-1038.
- Required claim note: MSA-1038 on file.

Medicaid Coverage Update per L 15-48 letter to providers where certain eligibility groups were affected by systems issues and received retroactive coverages:

- Required claim note: MAGI Corrective Action.
- Providers are directed to resubmit for consideration, any claims denied for eligibility edits for those Medicaid beneficiaries in the groups described in L 15-48 no later than March 31, 2016.

TPL Recovery (VOID) - Provider needs to re-bill:

- When 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 DD/MM/YYYY.**
- *This comment is 67 characters- only the first 80 characters of notes/comments can be read.*

Retroactively dis-enrolled from a Medicaid Health Plan (MHP) - Provider needs to re-bill Medicaid Fee For Service (FFS):

- Re-bill CHAMPS on a new clean invoice within 120 days from the MHP take-back.
- Required claim note: **Paymt taken back by MHP on DD/MM/YYYY MHP disenroll retro due to elig change.**
- *The above comment is 77 characters –only the first 80 characters of notes/comments can be read.*

Private insurance adjusts payment - Provider needs to re-bill:

- When private insurances change coverage parameters retroactively and take back or adjust their payments, rebill CHAMPS on a new clean invoice within 120 days of the takeback.
- Required claim note: **Paymt take back by Primary Ins. on DD/MM/YYYY due to retro elig change**.
- *This comment is 71 characters - only the first 80 characters of notes/comments can be read.*