MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-37

Distribution: All Providers

Issued: November 30, 2016

Subject: Timely Filing Billing Limitation

Effective: January 1, 2017

Programs Affected: MI Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver Program, Hospice, Maternity Outpatient Medical Services, MI Child, Children's Serious Emotional Disturbance Waiver, Emergency Services Only

The purpose of this bulletin is to update the billing limitation policy, hereafter identified as timely filing, in accordance with 42 CFR Section 424.44. To increase efficiency and accountability, the Michigan Department of Health and Human Services (MDHHS) is initiating changes to Fee-for-Service (FFS) claim submission requirements related to timely filing.

I. General Information

Medicaid FFS timely filing policy states that a claim must be initially received and acknowledged by MDHHS within 12 months from the date of service. Claims over one year old must have continuous active review to be considered for Medicaid reimbursement. A claims replacement can be resubmitted within 12 months of the latest remittance advice date or other activity.

Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Social Security Act, as well as the Medicare regulations at 42 CFR §424.44, specify the time limits for filing Medicare FFS (Part A and Part B) claims. Section 6404 of the Affordable Care Act (ACA) reduced the maximum period for submission of all Medicare FFS claims to no more than 12 months (one calendar year) after the date services were furnished.

II. Timely Filing Limits for Claim Submission

Effective January 1, 2017, claims must be filed no later than one calendar year from the date of service (DOS). For Institutional invoices, this will be calculated using the Claim Header "To/Through" date of service reported; for professional and dental invoices, this will be calculated using the Claim Line "From" date of service.

In addition, claims for services furnished prior to January 1, 2017 must be submitted no later than December 31, 2017. Claims exceeding the new timely filing limits (over 1 year from the DOS) will be denied unless the claim meets exception(s) as listed below.

A. Exceptions to Timely Filing Limits

Acceptable exceptions to the timely filing limits for claims submission include the following:

- Department administrative error has occurred
- Medicaid beneficiary eligibility/authorization was established retroactively
- Judicial action/mandate: A court or Michigan Administrative Hearing System (MAHS) administrative law judge ordered payment of the claim
- Medicare processing was delayed
- Provider returning overpayment
- Primary insurance taking back payment after timely filing billing limitation has passed

Retroactive provider enrollment is *not* considered an exception to timely filing.

III. Billing Instructions

For claims meeting either of the first two exceptions, providers must contact the local MDHHS office to initiate the following exception process:

- The MDHHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038).
- The provider must access the MSA-1038 status tool at www.mihealth.org or contact the caseworker to determine approval or denial of the request.
- Once approved the provider prepares the claims related to the exception including "MSA-1038 on file" in the comment section of the claim.
- The provider submits the claims to MDHHS through the normal submission process.

Claims meeting all other exceptions are to be submitted as usual through the Community Health Automated Medicaid Processing System (CHAMPS) with appropriate remarks/notes justifying the exception request, such as:

- Court order
- Medicare documentation
- Claims previously billed under a different provider National Provider Identifier (NPI) number
- Claims previously billed under a different beneficiary ID number
- Claims previously billed using a different "statement covers period" for nursing facilities and inpatient hospitals
- Copy of insurance letter or Explanation of Benefits (EOB) showing date money was taken back from paid claim

For requests regarding Medicare or other primary insurance exception the claim must be submitted within 120 days of the Medicare/primary insurance remit date in order to be considered for reimbursement.

Documentation supporting exception requests may also be submitted for consideration and review. Claims submitted later than one calendar year from the date of service without Remarks/Notes will be denied.

IV. Reimbursement

Claims meeting the timely filing limits will be subject to any additional coverage parameters such as eligibility, correct coding and validation. Providers may refer to the Medicaid Code and Rate Reference tool as well as the Medicaid Provider Manual for additional information regarding claim completion requirements. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms. Claims not meeting the timely filing limits will be denied.

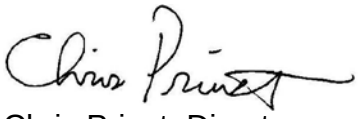
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Chris Priest, Director
Medical Services Administration