Insights

FSSA Revises Timely Filing Limit for Fee-For-Service Claims to 180 Days

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On June 19, 2018, the Family and Social Services Administration's ("FSSA") Indiana Health Coverage Programs ("IHCP") released provider bulletin BT201829 regarding revising the timely filing limit for Medicaid fee-for-service claims. Beginning January 1, 2019, Medicaid fee-for-service claims will be required to be filed within 180 calendar days from the date of service. For inpatient claims, the 180 day limit will be based on the IHCP member's date of discharge. Currently, the timely filing limit for Medicaid fee-for-service claims is 365 days, which will continue for claims with dates of service or dates of discharge on or before December 31, 2018. Notably, FSSA originally announced the agency's intent to decrease the timely filing limit to 90 days, similar to the timely filing limit for managed care claims, but FSSA agreed to 180 days after negotiations during the 2018 legislative session.

Exclusions

Crossover claims and overpayment adjustment requests will continue to be excluded from the timely filing limit. Accordingly, for crossover claims, Medicare or Medicare Replacement Plan primary claims containing paid services will not be subject to the 180 day timely filing limit, but if Medicare or a Medicare Replacement Plan denies a claim, the 180 day timely filing limit will apply to the Medicaid claim. Further, for overpayment adjustment requests, such requests must be returned regardless of the 180 day timely filing limit.

Extensions

The reasons for extending the timely filing limit (beyond the 180 days) will also remain unchanged, as follows:
If a member's eligibility is effective retroactively, the timely filing limit is extended to 180 days from the date eligibility was established. Documentation identifying retroactive eligibility must be included.

- If prior authorization ("PA") for a service is approved retroactively, the timely filing limit is extended to 180 days from the date the PA was approved. A copy of the approved PA stating "retroactive prior authorization" must be included.
- If an IHCP policy change is effective retroactively, the timely filing limit is extended to 180 days from the date of publication of the policy change. A copy of the publication must be included.

- For waiver providers, if a plan of care is delayed, the timely filing limit is extended to 180 days from the date that the plan of care was issued late. Documentation that the plan of care was issued late must be included.
- If third-party payer notification is delayed, the timely filing limit is extended to 180 days from the date on the explanation of benefits from the primary payer. A copy of the primary payer's explanation of benefits must be included.

Waivers

The circumstances under which the timely filing limit may be waived will remain unchanged as well, as follows:

- Lack of timely filing is due to an error or action by DXC Technology, OptumRx, or the State of Indiana. Documentation that clearly identifies the error or action that delayed proper adjudication of the claim must be included.
- Reasonable and continuous unsuccessful attempts by the provider to receive payment from a third party, such as Medicare or another insurance carrier. Documentation that clearly identifies multiple filing attempts in a timely manner along with all responses from the payer or third party must be included.
- Reasonable and continuous unsuccessful attempts by the provider to resolve a claim problem. Documentation that clearly identifies multiple filing attempts to correct and resolve claim problems in a timely manner along with all responses must be included.

If you have any questions regarding this change or related matters, please contact Amy M. Levander at alevander@kdlegal.com or your regular Krieg DeVault attorney.

[1] See IHCP Bulletin BT201829, available at: http://provider.indianamedicaid.com/ihcp/Bulletins/BT201829.pdf