WISCONSIN MEDICAID

UPDATE

OCTOBER 22, 1997

UPDATE 97-34

TO:
All Providers
HMOs and Other Managed Care Programs

Claim Submission Deadline and Exceptions

This Update summarizes existing Medicaid policy regarding the claim submission deadline and the eight exceptions to the deadline.

Providers must submit all claims within 365 days

State and federal laws require providers to submit all claims, including all adjustments to claims, within 365 days from the date of service.

Adjustments to claims may include correcting billing errors, adding and deleting services, and requesting medical consultant review. (Providers must use adjustment request forms when making claim adjustments.)

Providers must correct all billing errors and submit corrected claims or adjustment forms within 365 days from the date of service.

To resolve claim problems within 365 days from the date of service, Wisconsin Medicaid advises providers to use all available resources. Available resources include Medicaid publications, EDS (Medicaid Fiscal Agent) Provider Correspondence Unit for Policy/Billing Information, and EDS Professional Relations Representatives.

State and federal laws allow only eight exceptions

State and federal laws provide only eight exceptions to the requirement that providers submit claims correctly within 365 days from the date of service. Refer to the attachment for the eight exceptions.

Wisconsin Medicaid has no authority to approve any other exceptions. For more detailed information, refer to Section IX in Part A, the all-provider handbook.

No other exceptions

Wisconsin Medicaid has no authority to approve any other exceptions to the 365 days from the date of service claim submission deadline. HFS 106.03, Wis. Admin. Code, permits only eight exceptions to the claim submission deadline. Wisconsin Medicaid's exceptions to the claims submission deadline are not appealable, as stated in HFS 106.12, Wis. Admin. Code, and are not waivable under HFS 106.13, Wis. Admin. Code.

Claim or adjustment submission delays not considered exceptions

Claim or adjustment submission delays *do not* qualify as one of the eight exceptions. Examples of delays include:

- Providers not correcting claims after EDS denies the claims correctly. (Providers sometimes have submitted the same claim numerous times without making the necessary corrections.)
- Providers not resubmitting or adjusting a claim that was processed with a keying error within 365 days of the date of service.

- Providers' billing errors, regardless of the number of times that providers submitted claims before the filing deadline.

- Providers' billing staff problems, including personnel changes.

- Provider billing agents not following up on incorrect billing procedures.

- Slow response by health insurance. (Refer to Section IX-D of Part A, the all-provider handbook for instructions regarding prompt handling of claims involving health insurance.)

- Claims or adjustments received by EDS beyond the special filing deadline for late billing exceptions.

Exceptions to Submitting Claims within 365 Days

(HFS 106.03, Wisconsin Administrative Code)

1. Eligibility Denial

This exception exists when a claim is initially received by EDS within 365 days of the date of service but denied due to an error on the EDS eligibility file or incorrect HMO designation.

Submit the following documentation to EDS within 455 days from the date of service to have the claim resolved:

- Properly completed claim or adjustment (adjustment form copy is in Appendix 27 of Part A, the all-provider handbook).
- A copy of the Remittance and Status (R&S) report showing the claim was submitted in a timely manner and denied for an eligibility related Explanation of Benefits (EOB). EOB codes may include 29 (last name incorrect), 172 (not eligible for dates of service), 281 (incorrect recipient Medicaid ID number), 293 (Good Faith Claim Denied - certifying agency did not verify recipient eligibility within 70-day period), 418 (Good Faith Claim previously denied by certifying agency - resubmit claim with copy of Medicaid ID card), or 614 (first name incorrect).
- A copy of the recipient's Medicaid ID card. (This is not necessary, but helpful.)

Send documentation to:
Good Faith-Late Billing
EDS
6406 Bridge Road
Madison, WI 53784-6215

2. Change in Level of Care or Liability Amount

This exception exists when a nursing home claim is reimbursed incorrectly due to an error in the recipient's authorized level of care or liability amount on the EDS eligibility file and the claim was initially received by EDS within 365 days of the date of service. Submit the following documentation to EDS within 455 days from the date of service to have the claim resolved:

- Late Billing Request Form (a copy of the form is in Appendix 24 of Part A, the all-provider handbook) indicating the late billing exception.
- Properly completed claim or adjustment. Indicate on the adjustment request form the correct liability amount or level of care. The adjustment request form must indicate the most recent claim number, even if that claim or adjustment was submitted by EDS.

Send documentation to:
Late Billing Appeals
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215

3. Retroactive Eligibility

This exception exists when a decision is delayed by the certifying agency regarding the recipient's effective date of eligibility. Special consideration is given to claims if retroactive eligibility prevented the timely submission of the claim.

Submit the following documentation to EDS within 180 days after the mailing of the backdated Medicaid identification card to the recipient:

- Properly completed claim.
- "Retroactive eligibility" indicated on the face of the claim.

Send documentation to:

Late Billing Appeals
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215

4. General Relief (GR) Retroactive Eligibility

This exception exists when the local certifying agency requests a previous payment back from the provider because a recipient has become retroactively eligible for Wisconsin Medicaid.

Submit the following documentation to EDS within 180 days after the mailing of the backdated Medicaid identification card to the recipient:

- Properly completed claim.
- "GR retroactive eligibility" indicated on the face of the claim or copy of the county letter attached.

Send documentation to:

GR Retro-Eligibility
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215

5. Medicare Payment/Denial

This exception exists when claims submitted to Medicare within 365 days of the date of service are paid/denied by Medicare after the Medicaid 365-day claim submission deadline. (Please note that a waiver of the filing deadline may not be authorized for all Medicare denials.)

Submit the following documentation to EDS within 90 days from the Medicare Explanation of Medicare Benefits (EOMB) date:

- Late Billing Request Form indicating the late billing exception.
- Copy of the Medicare EOMB.
- Properly completed claim including the appropriate Medicare payment/denial determination.

Send documentation to:

Late Billing Appeals
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215

6. Refund Request from Private Insurance or Medicare

This exception exists when a review of previously paid claims by Medicare or private insurance companies determines that reimbursement was inappropriate.

Submit the following documentation to EDS within 90 days from the recoupment notification date:

- Late Billing Request Form indicating the late billing exception.
- A copy of the recoupment notification letter from the insurance company or Medicare.
- Properly completed claim or adjustment.
- Remittance and Status Report showing Medicaid recoupment for crossover claims, when appropriate.

Send documentation to:

Late Billing Appeals
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215

7. Medicaid Reconsideration

This exception exists when Wisconsin Medicaid identifies an inappropriate reimbursement due to a review of a previously submitted claim or due to a change in reimbursement rate. Wisconsin Medicaid will initiate an adjustment on a previously paid claim.

Submit the following documentation to EDS within 90 days from the date of the Remittance and Status (R&S) Report message if a subsequent provider submission is required:

- Late billing request form indicating the late billing exception.
- A copy of the R&S report message showing the Medicaid initiated adjustment.
- Properly completed claim or adjustment.

Send documentation to:

Late Billing Appeals
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215

8. Fair Hearing/Court/Department Decision

This exception exists when a decision is made by a court, fair hearing, or the Department of Health and Family Services (DHFS).

Submit the following documentation to EDS within 90 days from the date of the decision of the hearing:

- A complete copy of the notice from the fair hearing, court, or department decision.
- Properly completed claim for services related to the notice.

Send documentation to:

Late Billing Appeals
EDS
6406 Bridge Road, Suite 50
Madison, WI 53784-6215