Network Notification

Date: January 4, 2019
To: Kentucky Medicaid Providers
From: Humana – CareSource®
Subject: UPDATE – Change in Claim Timely Filing, Claim Appeal and Retrospective Review Time Frames

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Humana – CareSource® listened to our providers' concerns and is providing clarification related to the timely filing, claim appeal, payment rate dispute and retrospective review time frames.

BACKGROUND

Our previous notification on Dec. 29, 2017, detailed that effective April 1, 2018, providers must submit claims to Humana – CareSource within 180 calendar days of the date of service or discharge. If a claim is denied, providers have 180 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal. Additionally, retrospective reviews for medical necessity requests should be submitted to Humana – CareSource within 90 calendar days of the date of service, the inpatient discharge date or the primary insurance carrier's explanation of payment (EOP). Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. Please note the effective date of the Dec. 29, 2017, notice does not change with these clarifications.

Please note: The effective date of April 1, 2018, does not change with these clarifications.

SUMMARY

This notification provides clarification on timely filing requirements for:

- **Claims and appeals**
- **Coordination of benefits (COB) claims**
- **Retroactive eligibility claims**
- **Retrospective reviews**
- **Payment rate disputes**

CLAIMS AND APPEALS

- **Providers have 180 calendar days from the date of service or discharge to submit a claim. If a provider submits a claim after 180 calendar days, the claim will be denied as outside timely filing parameters. (Dec. 29, 2017, network notification)**
- **Claims will be denied if they contain incomplete, incorrect or unclear information. (Provider Manual, Claims Submission section, starting at Page 8)**
- **If a provider does not agree with the decision on a processed claim, the provider has 180 calendar days from the date of the original claim submission denial to file an appeal. (This is a change that is less restrictive to the provider thus will be effective the date of this notice.)**
- **If the claim appeal is not submitted in the required time frame, the claim will not be considered, and the appeal will be denied. (Dec. 29, 2017, network notification and Provider Manual, Page 16)**

COORDINATION OF BENEFITS (COB) CLAIMS

- **If a member has other insurance and Humana – CareSource is secondary, the provider may submit a claim for secondary payment within 180 calendar days of the original date of service. (Dec. 29, 2017, network notification)**
- **If the initial timely filing period has passed, the provider must submit a paper claim along with the primary payer's EOP to Humana – CareSource within 90 days of** the primary payer's EO**P date. If the claim and EOP are not submitted within the required 90-day time frame, the claim will be denied for timely filing. (Provider Manual, Page 16)**
- If a claim is denied for missing COB information, the provider must submit the primary payer's **EOP (for paper claims) or the** primary carrier's payment information **[for electronic data exchange (EDI) claims] within the rest of the initial timely filing period. If the initial timely filing period has passed, the provider must submit the EOP to Humana – CareSource within 90** calendar days from the primary payer's EOP date. If **the claim and EOP are not submitted within the required time frame, the claim will be denied as outside timely filing parameters. (Provider Manual, Page 16)**
- **Please note that some Medicare clearinghouses strip the taxonomy from the claim when sending it to Humana – Caresource. If that happens, Humana – CareSource will reject the claim as it does not meet the clean claim requirements set forth by the Kentucky Department for Medicaid Services (KDMS) related to National Provider Identifier (NPI) taxonomy. Please refer to the Dec. 11, 2013 network notification for the claim NPI taxonomy requirements and the Aug.16, 2018 network notification for federally qualified health centers (FQHCs) and rural health clinics (RHCs) taxonomy update. To avoid payment delays, please submit these claims on paper for secondary payment within the timely filing requirements detailed above.**

RETROACTIVE ELIGIBILITY CLAIMS

- **If a member retroactively enrolled with Humana – CareSource and was not enrolled with another managed care organization (MCO), the provider has 180 calendar days from the date of enrollment notification by KDMS to submit the claim to Humana – CareSource. The provider should submit these claims on paper and include the KDMS enrollment notification date.**
- **If a member retroactively enrolled with Humana – CareSource and was previously enrolled with another MCO, the provider must submit on paper:**
    - **The claim**
    - **A copy of the EOP reflecting recoupment of payment from the previous MCO**
    - **Documentation from the previous MCO to confirm the original encounter has been voided and accepted by KDMS or an attestation detailing the provider never billed the previous MCO for the service**
- **If a claim has exceeded timely filing requirements because of retroactive eligibility, the provider** has 90 days from the date of the accepted voided encounter in KDMS' system **to submit the claim to Humana – CareSource (Provider Manual, Page 25).**

RETROSPECTIVE REVIEWS

A retrospective review is a request for a review for authorization of care, service or benefit for which an authorization is required but not obtained before the delivery of the care, service or benefit. Humana – CareSource requires prior authorization to ensure covered patients receive medically necessary and appropriate services.

- **In the event that prior authorization was not obtained, providers have 90 calendar days from the** date of service, the inpatient discharge date or the primary insurance carrier's EOP to request a **retrospective review for medical necessity.**

- **Requests for retrospective review that exceed this time frame will be denied and are ineligible for appeal.**
- **Clinical information supporting the service must accompany the request.**

Providers can request retrospective review by contacting the Utilization Management department at 1-855-852-7005 and following the appropriate menu prompts. Providers also may fax the request to 1-888-527-0016. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

PAYMENT RATE DISPUTES

Providers have 24 months from the date a claim payment was received to notify Humana – CareSource of a payment error. Providers must notify Humana – CareSource through the following means:

- **Call Provider Services at 1-855-852-7005.**
- **Contact their assigned Humana – CareSource Health Partner Engagement Representative directly or by email kyproviderengagement@caresource.com**
- **Contact Avesis at 1-888-211-0599 for dental claim payment errors.**
- **Contact Beacon at 1-888-249-0478 for behavioral health claim payment errors.**