



Network Notification

Date: August 27, 2010

Number: MI-P-2010-11

To: Michigan Providers

From: CareSource

Subject: Timely Filing Revisions for Claim Appeals, Corrected Claims, Medical Necessity Appeals

Effective Date: September 1, 2010

CareSource is revising its timely filing requirements for claim appeals and medical necessity appeals.

The new guidelines for claim appeals and medical necessity appeals are as follows:

- **Claim Appeals** – Now 365 days (previously 90 days)
- **Medical Necessity Appeals** – Now 180 days (previously 90 days)

Conditions of Timely Filing:

- The filing period will be counted from the date of service, discharge date, or date of denial if service is not yet rendered (whichever is later).
- Appeals having previously gone through the formal appeals process are deemed to be final.

See the detailed chart on page 2 for additional clarification



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Term	Definition	Previous Window	New Window
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.	365 days	365 days from date of service or date of discharge
Medical Necessity Appeals With or Without a Claim	An appeal in which the provider was denied authorization or reimbursement. The appeal request may be submitted by the provider with or without the related claim attached.	90 days	180 days from date of service, date of discharge or date of denial if service was not yet rendered
Coordination of Benefit Claims	Claims received from providers whereby CareSource is the secondary payer. The timeline allows the provider sufficient time to bill the primary payer, receive the appropriate rejections and submit the same to CareSource for processing. The specific COB billing practices are documented elsewhere.	365 days from date of service, or 90 days from other carrier's EOB	365 days from date of service or date of discharge, or 90 days from the other carrier's EOB or whichever is later
Claim Paid Incorrectly	A claim in which CareSource made an error in how the claim was adjudicated. The provider should identify the error and submit an appeal on the CareSource provider portal.	90 days	365 days from date of service or date of discharge
Corrected Claim	A claim in which the provider made an error. The claim should be identified as a "Corrected Claim" and resubmitted to CareSource for processing.	365 days	365 days from date of service or date of discharge
Claim Appeal	Appeal of a denied claim in which the provider billed a service and payment was denied or reduced and the provider disagrees with the decision. The provider may submit a request to appeal the case citing certain references or providing any documentation to justify the reimbursement request.	90 days	365 days from date of service or date of discharge
Retrospective Utilization Review Request	A request for a utilization determination after service has been delivered. It may or may not have been previously submitted on a claim.	180 days from date of service, or 90 days from other carrier's EOB	180 days from date of service or date of discharge, or 90 days from other carrier's EOB