Indiana Medicaid Resolutions Manual

NAME: **545 CLAIM PAST FILING LIMIT (HDR)**

ERROR TYPE: Form Edit

HEADER/DETAIL: Header

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

Set this edit when the days between the last date of service and the ICN date are greater than 180 days for fee-for-service claims, or 458 days (15 months) for encounter claims.

CRITERIA:

Set this edit if the number of days between the last date of service and the ICN date are greater than the 180 day filing limit for fee-for-service claims or greater than 458 days (15 months) for encounter claims, with EOB 0545.
CoreMMIS under BPA>Business Rules Editor>FE (Form Edits)>Select 545 and choose the claim type.

DISPOSITION:

Note: EOB 9999 with a Do Not Post status is for internal system use only. This EOB is used to avoid potential system processing abends. This EOB is not posted on the RA and the disposition may be ignored.

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
00	00	0545	DENY
00	11	0545	SUSPEND
00	21	0545	SUSPEND
00	23	0545	SUSPEND
00	30	0545	PAY
00	32	0545	PAY
00	33	0545	PAY
00	34	0545	PAY
00	50	0545	SUSPEND

00	51	0545	PAY
00	52	0545	PAY
00	55	0545	PAY
00	57	0545	PAY
00	61	0545	SUSPEND
00	64	0545	PAY
00	70	0545	DENY
00	72	0545	PAY
00	73	0545	PAY
00	80	0545	PAY
00	91	0545	SUSPEND

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
00	00	0545	DENY
00	11	0545	SUSPEND
00	21	0545	SUSPEND
00	23	0545	SUSPEND
00	30	0545	PAY
00	32	0545	PAY
00	33	0545	PAY
00	34	0545	PAY
00	50	0545	SUSPEND
00	51	0545	PAY
00	52	0545	PAY
00	55	0545	PAY
00	57	0545	PAY
00	61	0545	SUSPEND
00	64	0545	PAY
00	70	0545	PAY
00	72	0545	PAY
00	73	0545	PAY
00	74	0545	PAY
00	80	0545	PAY
00	91	0545	SUSPEND

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
00	00	0545	DENY
00	11	0545	SUSPEND
00	21	0545	SUSPEND
00	23	0545	SUSPEND
00	30	0545	DENY

00	32	0545	DENY
00	33	0545	DENY
00	34	0545	DENY
00	50	0545	SUSPEND
00	51	0545	PAY
00	52	0545	PAY
00	55	0545	PAY
00	61	0545	SUSPEND
00	64	0545	PAY
00	70	0545	DENY
00	72	0545	DENY
00	73	0545	DENY
00	74	0545	DENY
00	80	0545	PAY
00	91	0545	SUSPEND

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
00	00	0545	DENY
00	11	0545	SUSPEND
00	21	0545	SUSPEND
00	23	0545	SUSPEND
00	30	0545	PAY
00	32	0545	PAY
00	33	0545	PAY
00	34	0545	PAY
00	50	0545	SUSPEND
00	51	0545	PAY
00	52	0545	PAY
00	55	0545	PAY
00	57	0545	PAY
00	61	0545	SUSPEND
00	64	0545	PAY
00	70	0545	PAY
00	72	0545	PAY
00	73	0545	PAY
00	74	0545	PAY
00	80	0545	PAY
00	91	0545	SUSPEND

Claim Type: B - Professional Xover Claims **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
00	00	9999	PAY

EOB: 0545 - YOUR CLAIM WAS FILED PAST THE FILING TIME LIMIT WITHOUT ACCEPTABLE DOCUMENTATION.

ARC Code	ARC Description	Effective Date	End Date
29	The time limit for filing has expired.	19950101	22991231

Remark Code	Remark Description	Effective Date	End Date
N706	Missing documentation.	20140301	22991231

EOB: 9999 - PROCESSED PER POLICY.

ARC Code	ARC Description	Effective Date	End Date
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231

METHOD OF CORRECTION:

Claims with no attachments, including provider initiated adjustments setting this edit will be systematically denied with EOB 0545.

Mass Adjustments, Retro Rate Adjustments, EOM Spend-down and Reprocessing will be set to post and pay for this edit.

Suspended Regions need to be reviewed for the following exceptions:

Retroactive Eligibility. If provider indicates late or retroactive eligibility through the claim note process or by attaching documentation stating "retroactive" eligibility.

To check the audit trail of retroactive eligibility in the UI, perform the following actions:

Access the claim in the UI. Click on the @ symbol next to the member ID number while processing the claim in the data correction screen. In the member eligibility window go to open tab, member and scroll down to Benefit Plan Information. Click on the benefit plan association for the DOS on the claim based on the decision rules posted for the edit based on the Benefit Plan. Once the appropriate Benefit Plan is selected, select the AID category information and scroll to the bar at the top and click Audit. Select the appropriate Benefit Plan or Aid Category Audit History to determine the date eligibility was inserted (established). If greater than 180 days from the date of submission, deny the detail with, EOB 0512.

TPL Delay. If third-party payer notification is delayed, force the edit if the TPL EOB is 180 days from the date on the EOB from a primary payer. A copy of the primary payer's EOB must be included as an attachment to the claim, otherwise deny the detail with, EOB 0512.

Retroactive PA. If prior authorization (PA) for a service is approved retroactively, waive the filing limit if the PA is 180 days from the date the PA was approved. A copy of the approved PA stating "retroactive prior authorization" must be included as an attachment to the claim. If the attachment is not present, deny the detail with, edit 0512.

Lack of timely filing is due to an error or action by DXC, OptumRX, the State, or County . The claim must be submitted with documentation that clearly identifies the error or action that delayed proper adjudication of the claim, if documentation is not attached or shows proper action that delayed claim processing, deny the detail with, EOB 0512.

Waiver claims. The Waiver Review Findings letter can be used as documentation to substantiate forcing the 180 day filing limit. Additionally, the Plans of Care for waiver providers that are retroactive, may be used as documentation to waive the 180 day filing limit, otherwise, deny the detail with, EOB 0512.

Overpayment adjustment. Overpayment adjustment requests are not subject to timely filing limits. Any overpayment identified by a provider must be returned to the IHCP. Check claim notes or attachments for language such as "adjustment due to overpayment" or "overpayment adjustment," or if the claim adjustment form is submitted with "overpayment adjustment" listed as the type of adjustment. If any of these conditions are present, force the claim.

For special batch claims, follow special instructions to adjudicate the claim.

Indiana Medicaid Resolutions Manual