COLORADO
Department of Health Care Policy & Financing

Dear Provider,

This email is an update to the prior communications below. In May 2017, the Department of Health Care Policy & Financing (the Department) temporarily extended the timely filing period from 120 to 240 calendar days. **Effective June 1, 2018, the timely filing period will be extended to 365 days**. This is a permanent change, not a temporary extension.

System functionality to bypass EOB 1786 - "The date of service is out of timely filing" when the Medicare/Third Party Liability (TPL) Paid or Denied amount is included on the claim was not working previously. As a result, some claims were being denied incorrectly. This issue has now been resolved.

Providers who receive payment from Medicare or other insurance/TPL no longer need to attach the Explanation of Benefits (EOB) to the electronic claim. Providers have an additional 120 days from a Medicare payment or denial and must include the Medicare or TPL EOB date on the claim. Providers must keep the EOB and supporting documentation on file. Claims with commercial insurance/TPL must be received within 365 days with no additional extension.

Please read below for the updated timely filing policy, effective June 1, 2018:

- Providers always have **at least** 365 days from the date of service (DOS) to submit the claim. A timely filing waiver is only needed if the dates of service have exceeded 365 days and there is no previous Internal Control Number (ICN).
- Providers are required to **resubmit claims every 60 days after the initial timely filing period** (365 days from the DOS) to keep the claim within the timely filing period even if the claim denies. The previous ICN must be referenced on the claim, even if the claim is over 365 days. A copy of the Remittance Advice (RA) should **not** be included with the claim.
- If the original timely filing period expires, the next submission **must be received within 60 days of the last action**. The following are examples of acceptable proof of timely filing:
    - Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider
    - A backdate approval letter (new enrollments, affiliations or updates are **not** acceptable reasons for late filing). Providers must enroll and submit claims within 365 days from the DOS.
    - A load letter for eligibility backdate

Claims that are not able to be submitted within the 365-day guideline, but have one (1) of the above documents attached to the submission, will be put into suspended status and will be reviewed by the fiscal agent. Attachments should be submitted with the claim via the Provider Web Portal. The fiscal agent does not accept attachments via batch submissions.

Claims that were denied for timely filing outside of 240 days but are still within 365 days of the DOS as of June 1, 2018, can be resubmitted by the provider. DXC will not be reprocessing any previous claims that denied for timely filing.

Please note that this timely filing extension does not apply to dental claims submitted through DentaQuest or pharmacy (point of sale) claims submitted through Magellan; however, Durable Medical Equipment (DME) claims are subject to the updated 365-day

timely filing policy.

For more information on timely filing, refer to the General Provider Information Billing Manual and the Timely Filing Frequently Asked Questions (FAQs), located on the Provider FAQ Central web page.

Thank you,

Department of Health Care Policy & Financing

Dear Provider,

This email is an update to the prior communications below. The Department of Health Care Policy & Financing (the Department) previously stated that the 240-day timely filing extension would expire on May 1, 2018. This email is to notify you that the Department will continue applying the 240 calendar day timely filing limit after May 1, 2018, until further notice.

System functionality to bypass EOB 1786 - "The date of service is out of timely filing" when the Medicare/TPL Paid or Denied amount is included on the claim is not currently working. As a result, some claims are being denied incorrectly.

The Department and DXC are working to resolve this issue and will provide an update on this progress soon. Until a system fix has been implemented, Provider Submitted and Automatic Medicare Crossover and Third Party Liability (TPL) claims that are past 240 days from the date of service, but still within timely guidelines, can be submitted via the Provider Web portal with the EOB attached. Once the claim is submitted it will be suspended for manual review of the EOB.

Thank you,

Health First Colorado (Colorado's Medicaid Program)

Dear Provider,

The Department of Health Care Policy & Financing (the Department) recognizes some providers have had difficulties submitting claims during the transition to the new claims payment system, the Colorado interChange.

In an effort to ensure providers are appropriately paid for services to our members, the Department is extending the temporary timely filing extension for an additional six (6) months. Please note that this does not apply to dental services that are submitted to DentaQuest.

Effective May 12, 2017, the timely filing limit was extended to 240 calendar days.

Effective May 1, 2018, the limit will be changed back to 120 calendar days.

On May 1, 2018, all claims with a date of service (DOS) prior to January 1, 2018, will be outside the timely filing limit of 120 days, and providers will need to submit additional documentation to request a timely filing extension.

Examples of additional documentation are:

- A claim denial or payment on a Remittance Advice (RA) or 835. Payment is not an

adverse action, but will suffice as proof of timely filing, if the ICN of the denial or payment is referenced on the claim
- Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider
- Provider enrollment letter for initial enrollment approval or a backdate approval (affiliations or updates are not acceptable reasons for late filing)
- Load letter for eligibility backdate
- Affidavit of delayed notification of member eligibility

Claims that are not able to be submitted within the 240-day guideline, but have one (1) of the above documents attached to the submission, will be reviewed by the fiscal agent.

Note - Provider Enrollment Delays: Providers are advised to complete the enrollment process before rendering services to a member to ensure claims processing. However, in most cases, providers can be backdated 240 days from the date of the enrollment approval, as long as they are licensed and meet all other enrollment requirements through those dates. **Providers can use the approval letter as a timely filing waiver to submit any claims after their approved effective date.**

Further information on timely filing can be found in the General Provider Information Billing Manual.

Thank you,

Health First Colorado (Colorado's Medicaid Program)

Dear Provider,

This email is to let you know the Department and DXC Technology (DXC) are aware of an issue with *Provider Submitted and Automatic Medicare Crossover* and *Third Party Liability* claims and timely filing edits.

Providers have additional time to submit from the day of the Explanation of Benefits (EOB) from the primary insurance. If the claim is outside 240 days from the date of service, but Medicare Crossover or Third Party Liability (TPL) has paid or denied, the claim can still considered to be within timely filing.

Timely filing for Medicare crossover claims is 120 days from the date of payment or 60 days from the date of denial. For TPL claims, timely filing is 60 days from the date of payment or 60 days from the date of denial.

System functionality to bypass EOB 1786 (The date of service is out of timely filing) when the Medicare/TPL Paid or Denied amount is included on the claim is not currently functioning. As a result, claims are being denied incorrectly.

Until a system fix has been implemented to address this issue, *Provider Submitted and Automatic Medicare Crossover* and *Third Party Liability* claims that are past 240 days from the date of service, but still within timely guidelines, can be submitted via the Provider Web portal with the EOB attached. Once the claim is submitted it will be suspended for manual review of the EOB.

Dear Provider,

Please review this clarifying information in regards to the Timely Filing Extension email

(below) sent out earlier today.

Question:
Does this extension apply to claim adjustments and re-submissions?

Answer:
Technically, the only number that we're extending is the time-frame for submission from the original date of service (DOS).

Normally, providers have 120 days from the DOS to submit their claims (without needing to provide additional documentation). Beginning May 12, this number will be temporarily extended to 240 days.

If a provider is within the 240-day window from the DOS, they can still adjust or resubmit a claim as often as they need (within the 240-day window). It's not until a provider is outside of the original window for timely filing that they need to worry about the time-frame to resubmit a denied claim, adjust a claim, etc.; this time-frame is 60 days after the last claim-specific activity.

So yes, while we are not specially extending the time-frame for adjustments and re-submissions, providers are essentially being given an extension for those as well.

Dear Provider,

The Department recognizes some providers have had difficulties submitting claims during the transition to the new claims payment system (the Colorado interChange).

In an effort to ensure providers are appropriately paid for services to our members, we are temporarily changing the limit for timely filing.

Effective May 12, 2017, the timely filing limit will be extended to 240 calendar days.

Therefore, we recommend providers hold claims with a DOS after December 1, 2016 (that are outside the 120 days timely filing limit) and do not submit those claims until after May 12, 2017. The system will automatically calculate the additional time and **providers do not need to take action to receive the extension during claims submission.**

Effective November 1, 2017, the limit will be changed back to 120 calendar days.

On November 1, 2017, all claims with a DOS prior to July 4, 2017 will be outside the timely filing limit of 120 days, and providers will need to submit additional documentation to request a timely filing extension.

Examples:

- On May 1, 2017, a claim for DOS of December 1, 2016 will be **outside the timely filing limit** of 120 days, and **will** need to submit additional documentation to request a timely filing extension.

- On May 17, 2017, a claim for DOS of December 1, 2016 will be inside **the extended timely filing limit** of 240 days, and **will not** need to submit additional documentation to request a timely filing extension.

- On November 1, 2017, a claim for DOS of December 1, 2016 will **again be outside the timely filing limit** of 120 days, and **will** need to submit additional documentation to request a timely filing extension.

Thank you,

Health First Colorado (Colorado's Medicaid Program)

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