APA-1

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control No: 560 Department or Agency: Alabama Medicaid Agency

Rule No: 560-X-1-.17

Rule Title: Providers' Claims

_____ New Rule; ___X___ Amend; _____ Repeal; _____ Adoption by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? No

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? Yes

Is there another, less restrictive method of regulation available that could adequately protect the public? No

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? No

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? No

Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? Yes

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Does the proposed rule have any economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975 and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer: Stephanie Lindsay

Date: 1/22/2015

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APA-2

**ALABAMA MEDICAID AGENCY**

**NOTICE OF INTENDED ACTION**

**RULE NO. & TITLE:** 560-X-1-.17 – Providers' Claims

**INTENDED ACTION:** Amend 560-X-1-.17

**SUBSTANCE OF PROPOSED ACTION**: The above referenced rule is being amended to update paragraph references under the *Providers' Claims* criteria.

**TIME, PLACE, MANNER OF PRESENTING VIEWS:** Written or oral comments may be submitted to the Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Agency business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

**FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:**. Written/Oral comments concerning this change must be received by the Alabama Medicaid Agency no later than March 9, 2015.

**CONTACT PERSON AT AGENCY:** Stephanie Lindsay, Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Phone: (334) 242-5833.

Stephanie McGee Azar
Acting Commissioner

**Rule No. 560-X-1-.17 Providers' Claims.**

(1) Providers of services and supplies shall submit claims electronically.

(2) Instructions concerning claim forms completion and processing procedures are contained in the provider manual(s) posted to the Alabama Medicaid website.

(3) Time limits for Claim Submission.

(a) Medicaid will pay only clean claims submitted timely to its fiscal agent. A clean claim is a claim which can be processed for payment or denied without obtaining additional information from the provider. A timely claim is a clean claim which is received by the fiscal agent within one year of the date of service, unless a different limitation is specifically provided elsewhere in this Code.

(b) A claim which does not have sufficient information to be entered into the automated claims processing system will be returned to the provider (RTP) and will not be considered as a clean claim submitted timely to the fiscal agent.

(c) A clean claim which is not timely received by the fiscal agent will be denied as outdated, except as provided in paragraph (~~5~~4) below:.

(4) Exceptions to Time Limits for Claims Submission.

(a) Where a claim has been timely submitted to Medicare or other third party payor and the Medicaid claim is not timely received in payable form by the fiscal agent in accordance with paragraph (43), above, a clean claim may still be processed if received within 120 days of the notice date of the disposition by the third party payor with such date indicated on the face of the claim. If Medicare or other third party payor denies the claim, a copy of the denial notice must be attached.

(b) Where a claim is for services rendered to a recipient during a time period for which retroactive eligibility has been awarded and the claim is not timely received in payable form in accordance with paragraph (43), above, a clean claim may still be processed if received by the fiscal agent within one year of the date of the award notice.

(c) Where a claim has been paid by Medicaid and is subsequently recouped, a resubmitted clean claim which is not timely received in payable form in accordance with paragraph (43), above, may still be processed if received within 120 days of the recoupment date, with such date indicated on the face of the claim. A copy of the EOP showing the recoupment must be attached.

(i)This section shall not apply to claims recouped through medical record reviews and/or investigations. Recouped claims from medical record reviews and/or investigations are considered final and are not subject to resubmission. Medical record reviews include, but are not limited to, those performed by : the Medicaid Program Integrity Division, the Recovery Audit Contractor (RAC), the Medicaid Integrity Contractor (MIC) and Payment Error Rate Measurement (PERM) contractor.

(d) The agency may make payments at any time in accordance with a court order, or to carry out administrative review or hearing decisions taken to resolve a dispute.

(5) Time Limits for Claims Payments.

(a) Except as otherwise provided above, the Medicaid fiscal agent must process and pay all clean claims within 12 months of receipt of the claim.

(b) A provider who submits a clean claim to the fiscal agent should normally receive payment or denial within 30 days. If payment is not received within this time period, the provider should contact the fiscal agent for a status report of the claim.

(c) When a provider's efforts to receive payment for a claim, with the help of the fiscal agent are fruitless, the provider should write to the associate director for its program at Medicaid before the time limitation expires. Providers should contact the Third Party department at Medicaid if there are problems with TPL-related claims.

(6) Administrative Review of Claims Denied as Outdated.

(a) A provider who is denied payment on an outdated claim may request an administrative review of the claim. A written request for an administrative review should be addressed to the appropriate program area and must be received by Medicaid within 60 days of the date the claim becomes outdated, which is the time limit provided in paragraph (43)(a), except that a claim falling within one of the exceptions in paragraphs (54)(a), (b) or (c), above, becomes outdated at the expiration of the 120-day or one-year period, whichever is applicable.

(b) A provider is not entitled to a fair hearing on an outdated claim until after an administrative review of the claim. A hearing request received prior to or in lieu of a request for an administrative review will be treated in all respects as a request for an administrative review.

(c) It is the responsibility of the provider, when submitting outdated claims for an administrative review, to furnish adequate documentation of its good faith attempts to obtain payment of the claim, including copies of relevant EOPs and correspondence with the fiscal agent and Medicaid. The provider must also include an error-free claim to furnish the fiscal agent in cases where the decision is favorable.

(d) Where a provider has timely requested an administrative review, research of the claim history reveals that the claim was originally filed before it became outdated under paragraph (76)(a), and the provider has established that it made a good faith effort to file a clean claim, Medicaid shall have the authority to instruct the fiscal agent to waive the filing limitation and process the claim.

(e) The provider will be notified in writing of the review decision. A provider who has timely requested an administrative review and received an adverse decision may request a fair hearing in accordance with Chapter 3 of this Administrative Code. Such request must be in writing and received by Medicaid within 60 days of the date of the administrative review denial letter. A provider is not entitled to further administrative review or a fair hearing on an outdated claim which is processed under this rule and which is denied due to a provider error on the claim.

(f) If all administrative remedies have been exhausted and the claim is denied, the provider cannot collect from either the recipient (patient) or his/her sponsor or family.

**Author:** Robin Arrington, LTC Provider/Recipient Services Unit, Long Term Care Division
**Statutory Authority**: 42 C.F.R. Section 447.45; Social Security Act, Section 1902(a)(27).
**History:** Rule effective October 1, 1982. Amended April 11, 1985; January 1, 1986; ER April 27, 1987; August 10, 1987; March 12, 1988; May 12, 1989, December 14, 1990 and January 13, 1993. Amended: Filed August 21, 2002, effective November 15, 2002. Amended: Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed January 22, 2015