

PROVIDER BULLETIN

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TO: All Providers Participating in the NE Medicaid Program

FROM: Vivianne M. Chaumont, Director 
Division of Medicaid & Long-Term Care

BY: Bob Kane, Administrator
Medicaid Claims Unit

RE: **180 Days Timely Filing for All Medicaid Claims**

Please Share This Information With Administrative, Clinical and Billing Staff.

The current timely filing requirement for Medicaid claims is that “no more than 12 months have elapsed from the date of service when the claim is received by the Department.” See 471 NAC 3-002.01; item #3. Effective **January 1, 2013** the Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC) will make a change to the regulations, requiring the receipt of claims within 6 months (180 days) of the date of service.

Please note: *Exceptions* to current timely filing requirements, for example, *retro-active eligibility* and the *90 day adjustment period for adjudicated claims* will remain unchanged. In addition, Third Party Resources (TPR), Health Insurance, Medicare denials and Casualty insurance will also remain unchanged. Details on these exceptions may be found in 471 NAC 3.002.01A and 471 NAC 3.004.06, A through G.

This change is consistent with data that shows nearly 85% of providers file claims within 180 days or less of the date of service. This change is not expected to adversely impact the normal course of business for providers.

To stay informed of future developments and/or bulletins published, please refer to our Recent Web Updates page on the website: http://dhhs.ne.gov/medicaid/Pages/med_updates.aspx

If you have further questions or concerns about this information, please contact Bob Kane at bob.kane@nebraska.gov or 402-471-9382.