TO: Medical Care Advisory Committee

DATE: August 13, 2020

FROM: Caryl Chambliss

SUBJECT: Claims Payment Deadline Exception

Agenda Item No.: 8

Amendment to: §354.1003 under Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Time Limits for Submitted Claims

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: Program Initiative

Under §354.1003, most Medicaid providers must submit claims to the Medicaid claims administrator within 95 days from the date of service or the claims will be denied for late filing. Additionally, providers must adhere to claims filing and appeal deadlines, and all claims, including all appeals processes, must be finalized within 24 months of the date of service. On occasion, circumstances either partially or wholly beyond the providers' control result in claims being finalized outside of this 24-month timeliness requirement. The purpose of this amendment is to add an exception to the rule that allows HHSC to consider situations not already listed as exceptions to the provider 24-month time limit for filing claims, to the extent permitted by state and federal law, if the provider shows good cause. Exceptions for this reason are currently made on a case-by-case basis and adding this additional exception will bring the rule into alignment with current practice.

ISSUES AND ALTERNATIVES:

There are no anticipated issues or concerns related to this amendment. The amendment is intended to bring the rule into alignment with current practice. No alternatives were considered or proposed by stakeholders.

STAKEHOLDER INVOLVEMENT:

HHSC posted the draft amendment for informal external stakeholder review and comment from January 31, 2020 through February 14, 2020 and received no comments.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

August 13, 2020 Present to the Medical Care Advisory Committee
August 20, 2020 Present to HHSC Executive Council

September 2020	Publish proposed rules in Texas Register
January 2021	Publish adopted rules in Texas Register
January 2021	Effective date

REQUESTED ACTION: (Check appropriate box)

☒ The MCAC recommends approval of the proposed rules for publication.

☐ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 354 MEDICAID HEALTH SERVICES
SUBCHAPTER A PURCHASED HEALTH SERVICES
DIVISION 1 MEDICAID PROCEDURES FOR PROVIDERS

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §354.1003, concerning Time Limits for Submitted Claims.

BACKGROUND AND PURPOSE

Under §354.1003, most Medicaid providers must submit claims to the Medicaid claims administrator within 95 days from the date of service or the claims will be denied for late filing. Additionally, providers must adhere to claims filing and appeal deadlines, and all claims, including all appeals processes, must be finalized within 24 months of the date of service. On occasion, circumstances either partially or wholly beyond the providers' control result in claims being finalized outside of this 24-month timeliness requirement. The purpose of this amendment is to add an exception to the rule that allows HHSC to consider situations not already listed as exceptions to the provider 24-month time limit for filing claims, to the extent permitted by state and federal law, if the provider shows good cause. Exceptions for this reason are currently made on a case-by-case basis and adding this additional exception will bring the rule into alignment with current practice.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §354.1003(b) makes editorial changes in the reference to §354.2217 to clarify its location in the Texas Administrative Code, by replacing "of this title" with "of this chapter" and to add the title of §354.2217.

The proposed amendment to §354.1003(g) adds language clarifying that the forthcoming exceptions would only be considered to the extent they are allowed by federal law. The proposed amendment also adds new paragraph (4), which creates a new exception to the requirement that claims are processed within 24 months of the date of service. The new exception allows HHSC to consider situations not already listed in the rule as exceptions to the provider 24-month time limit for filing claims if the provider shows good cause.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rule will be in effect:

(1) the proposed rule will not create or eliminate a government program;
(2) implementation of the proposed rule will not affect the number of HHSC employee positions;
(3) implementation of the proposed rule will result in no assumed change in future legislative appropriations;
(4) the proposed rule will not affect fees paid to HHSC;
(5) the proposed rule will not create a new rule;
(6) the proposed rule will expand an existing rule;
(7) the proposed rule will not change the number of individuals subject to the rule; and
(8) the proposed rule will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rule does not impose any additional costs on small businesses, micro businesses, or rural communities that are required to comply with the rule.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rule is in effect, the public benefit of the rule will be to reduce administrative burden on providers and permit HHSC to pay claims when circumstances wholly beyond a provider's control result in claims being finalized outside of the 24-month timeliness requirement.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the proposed amendment does not require providers to alter their current business practices for filing claims.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@hhsc.state.tx.us*.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 20R006" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which directs the Executive Commissioner of HHSC to adopt rules as necessary to carry out the commission's duties; and Human Resources Code §32.021 and Texas Government Code §531.021(a), which authorize HHSC to administer the federal medical assistance (Medicaid) program.

The amendment affects Texas Government Code §354.1003 under Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Time Limits for Submitted Claims.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 438-3360.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language

(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION

PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 354 MEDICAID HEALTH SERVICES

SUBCHAPTER A PURCHASED HEALTH SERVICES

DIVISION 1 MEDICAID PROCEDURES FOR PROVIDERS

§354.1003. Time Limits for Submitted Claims.

(a) Claims filing deadlines. Claims must be received by the Health and Human Services Commission (HHSC) or its designee in accordance with the following time limits to be considered for payment. Due to the volume of claims processed, claims that do not comply with the following deadlines will be denied payment.

(1) Inpatient hospital claims. Final inpatient hospital claims must be received by HHSC or its designee within 95 days from the date of discharge or 95 days from the date the Texas Provider Identifier (TPI) Number is issued, whichever occurs later. In the following situations, hospitals may, and in one instance, must file interim claims:

(A) Hospitals reimbursed according to prospective payment may submit an interim claim after the patient has been in the facility 30 consecutive days or longer.

(B) Children's hospitals reimbursed according to Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) methodology may submit interim claims prior to discharge and must submit an interim claim if the patient remains in the hospital past the hospital's fiscal year end.

(2) Outpatient hospital claims must be received by HHSC or its designee within 95 days from each date of service on the claim or 95 days from the date the Texas Provider Identifier (TPI) Number is issued, whichever occurs later.

(3) Claims from all other providers delivering services reimbursed by the Texas Medicaid acute care program must be received by HHSC or its designee within 95 days from each date of service on the claim or 95 days from the date the Texas Provider Identifier (TPI) Number is issued, whichever occurs later. This requirement does not apply to providers who deliver long-term care services and are subject to the billing requirements under Title 40 of the Texas Administrative Code.

(4) Providers must adhere to claims filing and appeal deadlines and all claims must be finalized within 24 months of the date of service. Submitted claims that exceed this time frame and do not qualify for one of the exceptions listed in subsection (g) of this section will not be considered for payment by the Texas Medicaid program.

(5) The following exceptions to the claims-filing deadlines listed in this subsection apply to all claims received by HHSC or its designee regardless of provider or service type.

(A) Claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid recipient number on the date of service must be received by HHSC or its designee within 95 days from the date the Medicaid eligibility is added to HHSC's eligibility file. This date is referred to as the "add date."

(B) If a client loses Medicaid eligibility and is later determined to be eligible, or if the Medicaid eligibility is established retroactively, the claim must be received by HHSC or its designee within 95 days from the "add date" and within 365 days from the date of service.

(C) When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs (dually eligible), the claim must first be filed with Medicare. Claims processed by Medicare must be received by HHSC or its designee within 95 days from the date of Medicare disposition or final determination of any Medicare appeal decision.

(D) When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only should be submitted directly to Medicaid. The time limits in paragraph (1) of this subsection apply.

(E) When a service is billed to another insurance resource, the claim must be received by HHSC or its designee within 95 days from the date of disposition by the other insurance resource.

(F) When a service is billed to a third party resource that has not responded, the claim must be received by HHSC or its designee within 365 days from the date of service. However, 110 days must elapse after the

third party billing before submitting the claim to HHSC or its designee.

(G) When a Title XIX family planning service is denied by Title XX prior to being submitted to Medicaid, the claim must be received by HHSC or its designee within 95 days of the date on the Title XX Denial Remittance Advice.

(H) Claims for services rendered by out-of-state providers must be received by HHSC or its designee within 365 days from the date of service.

(I) Claims for services rendered by the County Indigent Health Care Program, for which certification of the expenditures of local or state funds is required, are due to HHSC or its designee within the 365-day federal filing deadline.

(J) Claims for services rendered by school districts under the School Health and Related Services (SHARS) program, for which certification of the expenditures of local or state funds is required, are due to HHSC or its designee within the 365-day federal filing deadline or 95 days after the last day of the Federal Fiscal Year (FFY), whichever comes first.

(K) Claims for services rendered by enrolled Medicaid providers under the Department of Assistive and Rehabilitative Services' Blind Children's Vocational Discovery and Development Program (BCVDDP), for which certification of the expenditures of local or state funds is required, are due to HHSC or its designee within 365 days from the date of service.

(b) Appeals. All appeals of claims and requests for adjustments must be received by HHSC or its designee within 120 days from the date of the last denial of and/or adjustment to the original claim. Appeals must comply with §354.2217 of this chapter (relating to Provider Appeals and Reviews)~~title~~.

(c) Incomplete Claims. Claims received by HHSC or its designee that are lacking the information necessary for processing will be denied as incomplete claims. The resubmission of the claim containing the necessary information must be received by HHSC or its designee within 120 days from the last denial date.

(d) Extension. If a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next business day following the weekend or holiday.

(e) Additional Exceptions to the 95-day Claim Filing Deadline.

(1) HHSC shall consider the following additional exceptions when at least one of the situations included in this subsection exists. The final

decision of whether a claim falls within one of the exceptions will be made by HHSC.

(A) Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the control of the provider, including but not limited to criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when the intentional acts of the employee or agent leads to termination of employment and filing of criminal charges against the employee or agent; or

(B) Delay or error in the eligibility determination of a recipient, or delay due to erroneous written information from HHSC or its designee, or another state agency; or

(C) Delay due to electronic claim or system implementation problems experienced by HHSC and its designee or providers; or

(D) Submission of claims occurred within the 365-day federal filing deadline, but the claim was not filed within 95-days from the date of service because the service was determined to be a benefit of the Medicaid program and an effective date for the new benefit was applied retroactively; or

(E) Recipient eligibility is determined retroactively and the provider is not notified of retroactive coverage.

(2) Under the conditions and circumstances included in paragraph (1) of this subsection, providers must submit the following documentation, if appropriate, and any additional requested information to substantiate approval of an exception. All claims that are to be considered for an exception must accompany the request. HHSC will consider only the claims that are attached to the request.

(A) All exception requests. The provider must submit an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.

(B) Exception requests within paragraph (1)(A) of this

subsection. The provider must submit independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

(C) Exception requests within paragraph (1)(B) of this subsection. The provider must submit the written document from HHSC, or its designee, that contains the erroneous information or explanation of the delayed information.

(D) Exception requests within paragraph (1)(C) of this subsection.

(i) The provider must submit the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

(ii) If the provider is requesting an exception based upon an electronic claim or system implementation problem experienced by HHSC or its designee, the provider must submit a written statement outlining the details of the electronic claim or system implementation problems experienced by HHSC or its designee that caused the delay in the submission of claims by the provider, any steps taken to notify the state or its designee of the problem, and a verification that the delay was not caused by the neglect, indifference, or lack of diligence on the part of the provider or its employees or agents.

(E) Exception requests within paragraph (1)(D) of this subsection. The provider must submit a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.

(F) Exception requests within paragraph (1)(E) of this subsection. The provider must submit a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the recipient. The explanation must contain dates, contact information, and any responses from the recipient.

(f) Exceptions to the 120-day appeal deadline. HHSC shall consider exceptions to the 120-day appeal deadline if the criteria listed in this subsection is met and there is evidence to support paragraphs (1) or (2) of

this subsection. The final decision about whether a claim falls within one of the exceptions will be made by HHSC. This is a one-time exception request; therefore, all claims that are to be considered within the request for an exception must accompany the request. Claims submitted after HHSC's determination has been made for the exception will be denied consideration because they were not included in the original request. An exception request must be received by HHSC within 18 months from the date of service in order to be considered. This requirement will be waived for the exceptions listed in paragraphs (2) and (3) of this subsection and subsection (g) of this section.

(1) Errors made by a third party payor that were outside the control of the provider. The provider must submit a statement outlining the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider's employee, or agent. This affidavit or statement should be made by the person with personal knowledge of the facts. In lieu of the above affidavit or statement from the provider, the provider may obtain an affidavit or statement from the third party payor including the same information, and provide this to HHSC as part of the request for appeal.

(2) Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit a statement from the original payor outlining the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider's employee or agent. In lieu of the above reimbursement entity's statement, the provider may submit a statement including the same information, and provide this to HHSC as part of the request for appeal.

(3) Claims were adjudicated, but an error in the claim's processing was identified after the 120-day appeal deadline. The error is not the fault of the provider but an error occurred in the claims processing system that is identified after the 120-day appeal deadline has passed.

(g) Exceptions to the 24-month claim payment deadline. To the extent allowed by federal law, HHSC shall consider exceptions to the 24-month claim payment deadline for the situations listed in ~~paragraphs (1) - (3) of~~ this subsection. The final decision about whether a claim falls within one of the exceptions will be made by HHSC.

(1) Refugee Eligible Status: The payable period for all Refugee Medicaid eligible recipient claims is the federal fiscal year in which each date of service occurs plus one additional Federal Fiscal year. The date of service for inpatient claims is the discharge date.

(2) Medicare/Medicaid Eligible Status: The payable period for Medicaid/Medicare eligible recipient claims filed electronically is 24 months from the date the file is received from Medicare by the claims administrator for Medicaid. The payable period for Medicaid/Medicare eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice.

(3) Retroactive Supplemental Security Income Eligible: The payable period for Supplemental Security Income (SSI) Medicaid eligible recipients when the Medicaid eligibility is determined retroactively is 24 months from the date the Medicaid eligibility is added to the eligibility file. This date is referred to as the "add date."

(4) Other HHSC approved situations: To the extent permitted by state and federal laws, rules, and regulations, HHSC may, at its sole discretion, consider other situations as exceptions to the provider 24-month time limit if the provider shows good cause.