# *Network Notification*

**Date:** **December 29, 2017**
**To:** **Kentucky Medicaid Health Partners**
**From:** **Humana – CareSource®**
**Subject:** **Change in Claim Timely Filing, Claim Appeal and Retrospective Review Timeframes**

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Effective **April 1, 2018**, claims must be submitted to Humana – CareSource within 180 calendar days of the date of service or discharge.

If a claim is denied, providers have 180 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal. Additionally, retrospective reviews for medical necessity requests should be submitted to Humana – CareSource within 90 calendar days of the date of service, the inpatient discharge date or within 90 calendar days of the primary insurance carrier's Explanation of Payment (EOP). Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal.

**Claim Processing Guidelines**

- Providers have 180 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 180 calendar days, the claim will be denied as outside timely filing parameters.
- Claims will be denied if incomplete, incorrect or unclear information is included.
- If a member has other insurance and Humana – CareSource is secondary, the provider may submit for secondary payment within 180 calendar days of the original date of service.
- If a provider does not agree with the decision on a processed claim, he or she has 180 calendar days from the date of service or discharge to file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered, and the appeal will be denied.
- If a claim is denied for missing Coordination of Benefits (COB) information, the provider must submit the primary payer's EOP for paper claims or primary carrier's payment information for Electronic Data Exchange (EDI) claims within the remainder of the initial claim timely filing period. If the initial timely filing period has passed, the EOP must be submitted to Humana – CareSource within 90 calendar days from the primary payer's EOP date. If a copy of the claim and EOP are not submitted within the required time frame, the claim will be denied as outside timely filing parameters.

**Retrospective Review Guidelines**

A retrospective review is a request for a review for authorization of care, service or benefit for which an authorization is required but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately.

- In the event that prior authorization was not obtained, you have 180 calendar days from the date of service, the inpatient discharge date or within 90 calendar days from the primary insurance carrier's Explanation of Payment (EOP) to request a retrospective review for medical necessity.
- Requests for retrospective review that exceed these timeframes will be denied and are ineligible for appeal.
- If the request is received within these timeframes and a medical necessity denial is issued, you may submit a request for an appeal within 180 calendar days from the date of the service, 180 calendar days from the inpatient discharge date or within 180 calendar days of the date of the adverse decision letter.
- If you are appealing on the member's behalf with the member's written consent, you have up to 90 calendar days from the date of service or the inpatient discharge date, or within 90 calendar days of the date of the adverse decision letter.

A request for retrospective review can be made by contacting the Utilization Management department at **1-855-852-7005** and following the appropriate menu prompts. You also may fax the request to 1-888-527-0016. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. Eastern time. Clinical information supporting the service must accompany the request.

Please refer to the Humana – CareSource Provider Manual (CareSource.com/documents/ky-medicaid-health-partner-manual/) for additional claim submission requirements that are not addressed in this network notification.

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