WAC 182-502-0150 Time limits for providers to bill the agency. Providers must bill the medicaid agency for covered services provided to eligible clients as follows:

(1) The agency requires providers to submit initial claims and adjust prior claims in a timely manner. The agency has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims and claims for major trauma services, see subsections (7) and (8) of this section;

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to the agency as described in the agency's current published billing instructions.

(3) Providers must submit the initial claim to the agency and have a transaction control number (TCN) assigned by the agency within three hundred sixty-five calendar days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders the agency to cover the service; or

(d) The date the agency certifies a client eligible under delayed certification criteria.

(4) The agency may grant exceptions to the time limit of three hundred sixty-five calendar days for initial claims when billing delays are caused by either of the following:

(a) The agency's certification of a client for a retroactive period; or

(b) The provider proves to the agency's satisfaction that there are other extenuating circumstances.

(5) The agency requires providers to bill known third parties for services. See WAC 182-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to the agency's billing limits.

(6) When a client is covered by both medicare and medicaid, the provider must bill medicare for the service before billing the initial claim to the agency. If medicare:

(a) Pays the claim the provider must bill the agency within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, the agency requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(8) After twenty-four months from the date the service was provided to the client, the agency does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the agency by a negotiable financial instrument, such as a bank check.

(9) The agency allows providers to resubmit, modify, or adjust any prescription drug claim with a timely TCN within fifteen months of

the date the service was provided to the client. After fifteen months, the agency does not accept any prescription drug claim for resubmission, modification, or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the agency. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) The agency allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 182-531-2000 (for physician claims) or WAC 182-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the agency. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the agency.

(13) If a provider fails to bill a claim according to the requirements of this section and the agency denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-039, § 182-502-0150, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-502-0150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-502-0150, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. WSR 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]