

Change to Timely Filing and Corrected Claim Submission Standards – Medicaid ONLY

Effective immediately, McLaren Health Plan has updated its [Provider Manual](#) regarding timely filing limitations for Medicaid.

Summary of Change

Providers now have **one (1) year or (365 calendar days) from the date of service or discharge** or 90 days from an administrative action taken by MHP (whichever is later) to submit initial claims, corrections and replacements for the **Medicaid line of business only**. Previously, MHP required corrected claims for Medicaid to be submitted within 90 days from the Evidence of Payment (EOP) statement date. This transition allows for a broader window to claim resolution.

New Submission Guidelines for Medicaid

- **Standard Filing:** Claims must be received within one year or 365 days from the date of service to be eligible for reimbursement.
- **Corrected Claims:** All corrections and resubmissions must be resolved within the one-year window.
- **Front-End Rejections:** Claims that fail front-end edits are not considered "clean" or "submitted." These must be corrected and successfully resubmitted within the same 365-day window.

As a reminder, MHP follows MDHHS guidelines for resubmitted and corrected claims. All claims must be resolved within one year from the date of service unless an exception exists as noted in the Provider Manual. Claims that receive a front-end rejection, whether submitted electronically or on paper, are not considered submitted or clean claims.

To be considered submitted or clean, a claim must contain all required data elements in the appropriate format. Claims that receive a front-end rejection must be corrected and resubmitted within one year or 365 calendar days from the date of service. A copy of a front-end rejection is not acceptable documentation of a claim submission for payment reconsideration purposes.

MHP doesn't pay a claim when it's unclear as to whether MHP is the primary or secondary payer. Prior to rendering services, always ask patients if they have coverage from more than one insurance carrier or if their injury is the result of an accident.

There are no changes to our Coordination of Benefits policy - claims should be submitted electronically. COB claims must be submitted to MHP within 12 months from the date of service or 90 days from the date of the primary payer's EOP. To ensure appropriate adjudication of secondary claims, the primary insurance payment must be reported at the line level, not at the claim level.

Providers who believe a service was denied inappropriately or that a claim did not pay correctly, are encouraged to do one of the following:

1. Complete the [Provider Claim Adjustment Form](#) (see Forms Section XVIII in [Provider Manual](#) or McLarenHealthPlan.org), attaching a paper copy of claim or the claim in dispute, and supporting documentation for the adjustment, and fax it to Customer Service at 833-540- 8648 for processing.
2. Contact Customer Service at 888-327-0671 to request a claim adjustment.

Requests for claim adjustments cannot be submitted electronically.

For further details, please refer to the updated McLaren Health Plan [Provider Manual](#). If you have questions regarding specific claims, please contact MHP Customer Service at 888-327-0671 or your [Provider Relations Representative](#).

McLaren Health Plan thanks you for the quality care you deliver!

FAQ: UPDATED MEDICAID TIMELY FILING & EXCEPTION CRITERIA

To assist your billing department with McLaren Health Plan's transition to the 365-day filing limit for corrected Medicaid claims, we have compiled the following frequently asked questions regarding the updated standards and the specific criteria for exceptions.

1. What is the new filing deadline for corrected claims?

Providers now have **365 calendar days** from the date of service (DOS) or discharge to submit a corrected claim or 90 days from an administrative action taken by MHP, whichever is later. This replaces the old rule of 90 days from the Evidence of Payment (EOP) statement. **This only applies to McLaren Health Plan's Medicaid line of business.**

2. My claim was rejected at the front-end. Does that count as meeting the deadline?

No. A front-end rejection (electronic or paper) means the claim was never officially "submitted" or "clean." You must successfully correct and resubmit these claims so they are received and accepted within the **365-day window**. A copy of a rejection notice is not valid proof of timely filing.

3. Is "Retroactive Provider Enrollment" an exception?

No. If a provider is enrolled with MHP retroactively, this does **not** waive the 365-day timely filing requirement.

Need Help?

For further details, please refer to the updated McLaren Health Plan [Provider Manual](#). Detailed instructions and forms can be found on the MHP Provider Portal. For further assistance, contact **MHP Customer Service** at 888-327-0671.