TEXAS
Department of
Human Services

**COMMISSIONER**
James R. Hine



November 4, 2003

To: CBA Home and Community Support Services (HCSS) Agencies
CBA/CCAD Adult Foster Care (AFC) Providers
CBA/CCAD Assisted Living Residential Care (AL/RC) Agencies
CBA/CCAD Emergency Response Services (ERS) Agencies
CBA/CCAD Home Delivered Meals (HDM) Agencies
CBA/CCAD Respite Care Agencies
Community Living Assistance and Support Services (CLASS) Agencies
Consolidated Waiver Program (CWP) Providers
Consumer Directed Services (CDS) Agencies
Consumer Managed Personal Assistant Services (CMPAS) Agencies
Day Activity and Health Services (DAHS) Agencies
Deaf-Blind with Multiple Disabilities (DB-MD) Agencies
Hospice Provider Agencies
Medically Dependent Children Program (MDCP) Providers
Nursing Facilities
Primary Home Care (PHC) Agencies
Programs of All-Inclusive Care for the Elderly (PACE) Agencies
Special Services to Persons with Disabilities (SSPD) Agencies
Therapy Providers

Subject: Long Term Care (LTC)
Information Letter No. 03-36
Provider Letter No. 03-28
**Application of the 12-Month Claims Submittal Rule Effective November 1, 2003.**

This information letter is notice of the first application of the 12-month claims submittal rules that were effective November 1, 2002. The rules gave providers 12 months from the end of the service month to submit claims for payment. For services delivered before November 1, 2002, providers were given 12 months from November 1, 2002 to submit claims. Therefore, all claims for services provided before November 1, 2002 must be submitted by November 1, 2003. Any claim for these services not submitted by November 1, 2003 will be denied with the Explanation of Benefit (EOB) F0250 – Late Billing – Claim must be filed 12 months from the end of the month of service or 12 months from the end of the eligibility add date (previously referred to as EOB 29 – Time Limit for Filing has Expired). The rules can be found at 40 Texas Administrative Code §§ 49.9, 19.2609, 19.1306 and 30.62. Any claim submitted for payment that is more than 12 months from the end of the service month will be denied with the EOB F0250.

A claim may be denied due to EOB F0250 through no fault of the provider agency, and the agency may ask the Texas Department of Human Services (DHS) to consider paying the claim even though the claim is over 12-months old.

**Documentation to DHS**

The provider agency must provide adequate documentation to DHS to support the request for payment for a claim that is over 12 months. Documentation must be provided as follows:

- Community Care Provider Agencies – provide to the Regional Claims Management System Coordinator
- Nursing Facility and Therapy Providers – provide to the Provider Claims Services Help Desk.

Documentation that must be provided includes, but is not limited to, the following:

1) The reason the claim denied. (For example, missing/incorrect eligibility/service authorization records, etc.);
2) A copy of the Remittance and Status (R&S) Report listing the claim that denied due to EOB F0250;
3) Form(s) 2101, 3671 or 2065 confirming services were authorized by DHS;
4) Form(s) 2067 documenting that the agency notified DHS about payment problems and/or missing information;
5) Timesheets/daily census records, etc., confirming that services were provided to the client;
6) Forms(s) 3618/3619 and 3652 or weekly status report showing the date accurate documents were submitted to DHS.

DHS will review the documentation to determine if the reason the claim denied was due to no fault of the agency. Provider agencies will be notified by DHS of approval/disapproval of the request for payment.

**Availability of Previous Information Letters**

Previous information letters listed below, on the same subject, may be found at the following address:

- For Community Care Provider Agencies: http://www.dhs.state.tx.us/programs/communitycare/infoletters/cbaccadletters.html under Community Care Information Letters.

- For Nursing Facilities and Therapy Providers: http://www.dhs.state.tx.us/providers/LTC-Policy/index.html under Communications: Provider Letters.

**Previous Information Letters**

1) Provider Letter No. 02-44 dated November 4, 2002, titled **"Submittal of Claims within 12 Months";**
2) Provider Letter No. 03-10 dated March 10. 2003 and Information Letter No. 03-03 dated March 11, 2003, titled **"First Reminder: Submittal of Claims within 12 Months;**
3) Information Letter No. 03-08 dated July 11, 2003 and Provider Letter No. 03-15 dated July 18, 2003, titled **"Second Reminder: Submittal of Claims within 12 Months;** and

4) Information Letter No. 03-27 and Provider Letter No. 03-25 dated August 29, 2003, titled **"Third and Final Reminder: Submittal of Claims within 12 Months.**

**Have questions about this information letter?**

- Community Care Provider Agencies – Contact your regional contract manager or CMS Coordinator
- Nursing Facility and Therapy Providers – Contact the Provider Claims Services Help Desk.

Sincerely,

*Signature on file*

Marilyn Eaton
Lead Director
Long Term Care Services

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