POLICY TITLE: Timely Filing - Advantage
POLICY #: RM-005

PARAMOUNT AND PROMEDICA HEALTH PLAN

APPLIES TO:	Paramount Advantage
EFFECTIVE DATE:	11/01/2019 - Original Date 07/01/2020 (administrative updates)
SCHEDULED ANNUAL REVIEW DATE:	July 1 (each calendar year)
PURPOSE:	This policy is a guideline only and does not constitute a benefit determination, medical advice, guarantee of payment, plan preauthorization, an Explanation of Benefits or a contract. This policy is not intended to address every claim situation. Whether a procedure is covered shall be determined based on the terms and provisions of a specific member plan or policy. Claims may be affected by other factors, such as state and federal laws and regulations, provider contract terms and our professional judgment.
DEFINITION:	N/A

POLICY:

Initial claim submission

This policy establishes timeframes for Medicaid claim submission. This policy applies to all initial claims submissions and adjustment requests for dates of service on and after 11/01/2019.

All providers need to submit clean claims per the timeframe listed in their Paramount Agreement or per applicable laws. We will allow the lesser of the time frame in the provider agreement or 365 days from the date of service. In no event will we allow more than 365 days.

If a participating provider fails to submit a clean claim within the timeframes outlined below, we reserve the right to deny payment for such claim. A provider cannot bill a member for claims denied for untimely filing. We have established internal claims processing procedures for timely claims payment to our care providers.

The claims "timely filing limit" is defined as the calendar day period between the claims last date of service or payment/denial by the primary payer, and the date by which Paramount receives the claim.

Determination of the claim receipt date: The date of receipt shall be regarded as the calendar day when a claim, by physical or electronic means, is first delivered to Paramount's specified claims payment office, post office box, designated claims processor for that claim.

Adjustments

Adjustment requests should be submitted electronically or using the Paramount Claim Adjustment/Coding Review Request form when applicable. Adjustments are resubmissions of previously submitted claims and are not considered provider appeals.

Adjustments of a previously adjudicated and paid claim (in full or by service line) must be submitted within the lesser of the timeframe listed in the applicable agreement or 180 days from initial payment/adjudication date.

Adjustments of a previously adjudicated and denied claim (in full or by service line) must be submitted within the lessor of the timeframe listed in the applicable agreement but in no event greater than 365 days from the date of service or 180 days from the date of initial adjudication/denial

Late claim appeals

Paramount understands that there are some circumstances that would warrant an appeal to this policy. If the provider would like to appeal a claim that is denied as untimely, the provider can submit a provider appeal. The appeal must include notes about accounts receivable actions. For example, include notes documenting calls with the Paramount Provider Inquiry team, or notes documenting that the member provided inaccurate information resulting in the untimely filing. If the documentation supports the untimely claim submission, the claim will be adjudicated and timely filing will be waived. If the documentation does not support the untimely claim submission, the total claim or line denial will stand.

Advantage	Timeframe	Denial Code
Initial Claim	**Lesser of the timeframe listed in the applicable agreement or 365 days from the date of service**	**Day 366 and greater deny 'D9'**
Adjustments – Paid (in full or service line)	**The lesser of the timeframe listed in the applicable agreement or 180 days from initial payment/adjudication date**	**Day 181 and greater claim will deny '9O' or '9P' depending on the original claim**
Adjustments – Denied (in full or service line)	**The lessor of the timeframe listed in the applicable agreement but in no event greater than 365 days from the date of service or 180 days from the date of initial adjudication/denial**	**Day 181/366 or greater claim will deny '9O' or '9P'**
Coordination of Benefits (COB) – Initial Claim	**180 days or less from the date Medicare or other plan paid the claim**	**Day 181 and greater claim will deny '9O' or '9P'**

EXCEPTIONS:

The following is a list of exceptions to this policy:

- Claims subject to coordination of benefits (submission allowed up to 180 days from the date of the other payor's payment date)
- Exceptions required by federal or state law, including but not limited to OAC 5160-1-19(E)