Medical Coverage Policy

Timely Filing Limit

☐ Device/Equipment ☐ Drug ☐ Medical ☐ Surgery ☐ Test ☒ Other

Effective Date:	2/15/2011	Policy Last Updated:	2/15/2011

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

Description:

The following are general requirements for filing of claims for participating providers; individual contracts may differ and supersede the information below.

The filing limit for claim submission for **professional services** to Blue Cross Blue Shield of Rhode Island (BCBSRI) for **commercial members** is 180 days from the date of service.

- For inpatient admissions, the filing limit is 180 days from the date of discharge.
- When coordinating benefits with a primary insurance carrier, such as Medicare, the filing limit for claims submission to BCBSRI is 180 days from the date that the primary insurer processed the claim; this process date must be indicated on the primary insurer's Explanation of Benefits (EOB), and the EOB itself must be included with the claim submission.
- Members cannot be billed for services denied because the filing limit was exceeded.

Time Limits

- Filing limit appeals must be received within 60 days of the original BCBSRI EOP date.
- Any claim with a date of service more than 60 days old will not be considered for filing limit appeal.
- An appeal received after the applicable appeal filing limit will not be considered and cannot be appealed.
- Members cannot be held liable for claims denied for exceeding the appeal filing limit.

Institutional claims filing time limits vary by contract; please refer to current contract.

Non-participating providers who are out of the service area (OOS) and local non-participating providers have one (1) year from date of service to file claims.

ITS Home: follow local plan timely filing process
ITS Host: follow our BCBSRI rules

BlueCHiP for Medicare claims filing limit is 365 days.

Claims Submission and Payment

A claim must be submitted for all services not included in a capitation compensation arrangement. Claims for non-capitated services provided by personal physicians will be considered for payment of allowable fees and accumulation of utilization data related to ambulatory services.

When the rendered services are included in a personal physician's capitation arrangement, a data-only claim is submitted. These claims are called encounter claims. All mandatory elements on a CMS-1500 form must be completed for encounters, including box 10A, which identifies work-relatedness.

Encounter data helps us evaluate network and physician-specific utilization of ambulatory services, and is an important aspect of our quality improvement program. All claims must be submitted within 180 days of the date of service.

Services Requiring Claims Submission

The following are examples of typical professional services that require claims submission:

- All office evaluation/management services, including new and established patient office visits, new and established patient preventive visits, and office consultations
- Surgical services
- Hospital visits and inpatient consultations
- Lab work, X-rays, and EKGs

Required Information

To ensure prompt payment, complete all mandatory fields on the claim form including, but not limited to:

- Personal information that identifies the member as a subscriber or dependent of a subscriber, and other pertinent data
- Coverage information, including the member's specific plan; coverage from other carriers; and any information that can help identify whether another party is financially liable for the charges
- Identifying rendering physician/provider information
- Identifying referral physician/provider information, if appropriate

- Charge of the service
- Patient treatment information, including diagnosis, CPT®, or HCPCS® code for the service and any applicable modifier(s), date services were rendered, and service site
- Tax identification number (TIN)

When the required information is not included, the claim will be denied. A new claim with correct and complete information must be submitted in order for a denied claim to be reconsidered. The Claims Adjustment Request Form, to be completed and submitted with a corrected claim, is available on the provider section of BCBSRI.com.

Clean Claims Defined: *A claim for payment of healthcare services that is submitted via acceptable claim forms or electronic formats with all required fields completed with accurate and complete information in accordance with the insurer's requirements.*

A claim is considered "clean" if the following conditions are met:

1. The services must be eligible, provided by an eligible provider, and provided to a person covered by the insurer.
2. The claim has no material defect or impropriety, including, but not limited to any lack of required substantiating documentation or incorrect coding.
3. There is no dispute regarding the amount claimed.
4. The payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation.
5. The claim does not require special treatment or review that would prevent the timely payment of the claim.
6. The claim does not require coordination of benefits, subrogation, or other third party liability.
7. Services must be incurred during a time where the premium is not delinquent. (This condition does not apply to BlueCHiP for Medicare members.)
8. If you have questions about whether or not your claims meet all conditions of a "clean claim," you may contact the Physician and Provider Service Center for more information.

Procedures

1. Complete a CMS-1500 claim form.

2. Submit the form to BCBSRI.

To be considered for benefit payment, you must submit a clean claim (as defined above) within 180 days of the date of service or completion of an inpatient stay, or monthly in the case of an extended stay. Although not submitted for payment purposes, encounter claims must also be received within the same timeframe.

Claims submitted after the time limit will be denied. Please remember that in accordance with your participating physician/provider agreement, **you may not "balance bill" patients for services that were denied because you did not meet timely filing requirements.**

Allowable Fees

Participating physicians/providers are required to accept as payment in full the amount allowed by BCBSRI for covered services less any applicable copayment or coinsurance collected from the member at the time of service. Disputed payments will be reconsidered upon request.

Appeals of Payment Determinations

You are entitled to a review and reconsideration of any claims payment that you believe is inaccurate or does not reflect an appropriate allowance for the services rendered. Administrative appeals are handled by BCBSRI's Grievance and Appeals Unit (GAU). GAU will acknowledge receipt of your appeal either orally via telephone or in writing via an acknowledgement letter. Our staff will complete the review and send you a determination letter. The entire process will be completed within 60 calendar days of our receipt of your appeal.

To report errors or request review of a payment (or adjustment), call the Physician and Provider Service Center, or write to or send the Provider Appeal Request Form to:

Attn: Grievance and Appeals Unit
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903