Reimbursement Policy

Subject: **Proof of Timely Filing**	
Policy Number: **G-06133**	Policy Section: **Administration**
Last Approval Date: **09/27/2023**	Effective Date: **11/19/2021**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.simplyhealthcareplans.com** or **https://provider.clearhealthalliance.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply and CHA may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Simply and CHA strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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Policy

Simply and CHA will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise when a provider can do one of the following:

- Provide a date of claim receipt compliant with applicable timely filing requirements or,
- Demonstrate Good Cause exists.

Documentation of Claim Receipt

The following information will be considered proof the claim was received within the time period outlined in the Claims Timely Filing policy. If the claim is submitted:

- **By mail**: The provider must provide official mailing service return receipt/delivery confirmation; additionally, the provider must provide a copy of the claim log that identifies each claim included in the submission.
- **Electronically**: The provider must provide the clearinghouse-assigned receipt date from the reconciliation reports.

The following information **will not be considered** proof the claim was received timely. If the claim is submitted:

- **By fax:** Facsimile transmission
- **By hand delivery:** A claim log that identifies each claim included in the delivery and a copy of the signed receipt

The mailed claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing
- Subscriber name
- Subscriber ID number
- Member’s name
- Date(s) of service/occurrence, total charge, and delivery method

Good Cause

Good Cause may be established by the following:

- If the claim includes an explanation for the delay (or other evidence which establishes the reason), Simply and CHA will determine good cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, Simply and CHA will contact the provider for clarification or additional information necessary to make a Good Cause determination.

Good Cause may be found when a provider claim filing delay was due to:

- Administrative error — incorrect or incomplete information furnished by official sources to the provider.
- Retroactive enrollment — member subsequently received notification of enrollment effective retroactively to or before the date of service.
- Incorrect information furnished by the member to the provider resulting in erroneous filing with another health insurance plan or with their state Medicaid plan.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the provider to secure such documentation or evidence.
- Unusual, unavoidable, or other circumstances beyond the service provider's control that demonstrate the provider could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the provider's records unless such destruction or other damage was caused by the provider's willful act of negligence.

Related Coding
Standard correct coding applies

Policy History	
09/27/2023	Review approved and effective: removed ability to submit claims by fax
11/19/2021	Review approved and effective: policy title updated; policy language updated; added hand delivery language; added the word *mailed* for claim log
05/24/2019	Review approved and effective: United States mail return receipt language updated; word physician replaced with provider
10/01/2018	Policy template updated
09/28/2017	Review approved: retroactive enrollment language added
11/09/2015	Review approved: First class language removed; policy template updated
11/18/2013	Review approved and effective: good cause language expanded
11/07/2011	Review approved: policy template updated
09/21/2009	Review approved: policy template updated
11/15/2006	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • State Medicaid

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Claims Timely Filing

Corrected Claims
Eligible Billed Charges