

Health Plus Medical & Claims Payment Bulletin

Bulletin number: CL - 303

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Subject: Timely Filing

Policy:

Claim Submission:

- All providers are required to submit claims for services reimbursed according to fee-for-service rates and for services provided under capitation within 120 days from date of service or date of discharge for inpatient facility claims.
- Health Plus will process claims submitted more than one hundred twenty (120) days from the date of service (unless otherwise specified in your contract) for the reasons listed below:

Note: all claims that meet the following criteria must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider’s control. In addition, the applicable “Reason for Delay” must be included on the written explanation.

Reason for Delay	Time Frame for Submission
Delay in member eligibility determination.	Within sixty (60) business days from the time of notification of eligibility (submit with documentation substantiating the delay).
Litigation involving payment of the claim.	Within sixty (60) business days from the time the submission came within the provider’s control.
Authorization Delays/Administrative Delay (enrollment process, prior approval process, rate changes, etc.) by NYSDOH or other State agencies.	No time frame.
Delay in Certifying Provider/Administrative Delay (enrollment process, prior approval process, rate changes, etc.) by NYSDOH or other State agencies.	No time frame.
Medicare or other Third Party Processing Delays affecting the claim.	Within sixty (60) business days from the time the submission came within the provider’s control.

Original claim rejected or denied due to a reason unrelated to the 120-day rule.	Within sixty (60) business days of the original date of denial or rejection (re-submit with original EOP).
IPRO (Island Peer Review Organization) Denial/Reversal.	No time frame.
Prenatal Care Claims because delivery was performed by a different practitioner.	No time frame.

- Incomplete or inaccurate claims that are returned to you for necessary information and resubmitted to Health Plus are re-adjudicated under the first received claim.
- If a claim is denied or returned for correction, it must be corrected and resubmitted within sixty (60) business days from the date of initial determination. Corrected claims not resubmitted within sixty (60) business days of the initial determination, will not be considered for payment.

Policies in this manual are intended to reflect standard Health Plus procedures. In instances where a provider's contract contains other policies which may be more or less restrictive than those in this manual, these contractual provisions will apply.

Date Approved:	5-16-06	Approved By:	<i>Clifford D. Marbut, M.D., M.P.H.</i>
Date Approved:	5-22-06	Approved By:	<i>[Signature]</i>