Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Timely Filing

Policy Number: RM009
Last Review: 02/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

This policy is to document the general requirements for the timely filing of claims by providers. Paramount will consider reimbursement for the initial claims, when received and accepted within the timely filing requirements, in compliance with federal and/or state mandates. Such claims must be filed to the appropriate claims processing contractor no later than 12 months, or 1 calendar year, after the date the services were furnished. All providers need to submit clean claims per the timeframe listed in their Paramount Agreement or per applicable laws. A "clean claim" has no defect, impropriety, lack of any required substantiating documentation, or circumstance requiring special treatment that prevents timely payment.

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

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

If a participating provider fails to submit a clean claim within the timeframes outlined below, Paramount will deny

payment for such claim. A provider cannot bill a member for claims denied for untimely filing.

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.

POLICY:
Elite (Medicare Advantage) Plans

Time Limitations for Filing Claims
In general, claims must be filed to Paramount no later than 12 months, or 1 calendar year, after the date the services were furnished. Elite (Medicare Advantage) Plans will allow at least 90 days for participating providers to submit clean claims. In no event will Paramount allow more than 365 days. If Paramount is not the primary payer, the provider will give 90 days from the date of payment, denial, or notice from the primary payer to submit 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 received by Paramount. The receipt date will be used for determining whether the claim was timely filed.

Determining Start Date of Timely Filing Period – Date of Service
In general, the start date for determining the 12-month timely filing period is the date of service on the claim.

- For institutional claims (Form CMS-1450, the UB-04 and now the 837 I or its paper equivalent) the "Through" date on the claim is used for determining the date of service for claims filing timeliness. Certain claims for services require the reporting of a line-item date of service.
- For professional claims (Form CMS-1500 and 837-P) the line item "From" date is used for determining the date of service for claims filing timeliness. (This includes DME supplies and rental items.) If a line item "From" date is not timely but the "To" date is timely, contractors must split the line item and deny the untimely services as not timely filed. Claims having a date of service on February 29 must be filed by February 28 of the following year to be considered timely filed.

Determination of Untimely Filing and Resulting Actions
Paramount denies a claim for untimely filing if the receipt date applied to the claim exceeds 12 months or 1 calendar year from the date the services were furnished as outlined above.

- Adjustments of a previously adjudicated and paid claim (in full or by service line) must be submitted within the timeframe listed in the applicable agreement, or 180 days from the date of initial adjudication/payment.
- Adjustments of a previously adjudicated and denied claim (in full or by service line) must be submitted within the timeframe listed in the applicable agreement, but in no event more than the greater of 365 days from the date of service or 180 days from the date the claim was initially adjudicated or denied.

When a claim is denied for untimely filing limit, and Paramount did not make an 'initial determination,' the claim is not subject to appeal or adjustment**.**

If Paramount's administrative claims processing determines that a late claim should be honored because the facts support that an error or misrepresentation has caused the claim to be late, the provider, supplier, or beneficiary will have until the end of the 6th calendar month from the month in which the provider, supplier, or beneficiary received notification that the error or misrepresentation has been corrected. There must be a clear and direct relationship between the Paramount's administrative error and the late filing of the claim.

Elite (Medicare Advantage) Plans	Timeframe

Initial claim	Lesser of the timeframe listed in the applicable agreement or 365 days from the date of service
Adjustments – paid (in full or service line)	The lesser of the timeframe listed in the applicable agreement or 180 days from the initial payment date of the claim
Adjustments – denied (in full or service line)	The lesser 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
Coordination of Benefits (COB) – initial claim	180 days or less from the date of the other payor's payment date

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.

Late claim appeals
Paramount understands there are circumstances which 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.

Paramount Commercial Insurance Plans
Paramount Commercial Insurance Plans allow no more than 365 days to submit a clean claim. If Paramount is not the primary payer, Paramount will give the provider at least 180 days from the day of payment, contest, denial, or notice from the primary payer to submit the claim.

Paramount Commercial Insurance Plans	Timeframe
Initial claim	Within the timeframe listed in the **applicable agreement** or when there is no applicable agreement timeframe than no more than 365 days from the date of service
Adjustments – paid (in full or service line)	Within the timeframe listed in the **applicable agreement** or when there is no applicable agreement timeframe than no more than 180 days from the initial payment date of the claim
Adjustments – denied (in full or service line)	Within the timeframe listed in the **applicable agreement** or when there is no applicable agreement timeframe than no more than 365 days from the date of service or 180 days from the date of initial adjudication/denial
Coordination of Benefits (COB) – initial claim	180 days or less from the date of the other payor's payment date

If Paramount, acting as a third-party payer, receives a claim, where a different third-party payer or a state or federal program, received and refused to process the claim as not responsible for the cost of the health care services, or if the provider does not submit the notice of denial from the different third-party payer or program with the claim, within forty-five (45) days the claim will be denied.

Adjustments of a previously adjudicated and paid claim (in full or by service line) must be submitted the lesser of the timeframe listed in the applicable agreement or 2 years (730 days) from the initial payment date of the claim.

Adjustments of a previously adjudicated and denied claim (in full or by service line) must be submitted the lesser

of the timeframe listed in the applicable agreement or 2 years (730 days) from the initial payment date of the claim.

Pursuant to Ohio Law, all claim payments are considered final two (2) years after payment is made. After that date, the amount is not subject to adjustment except in the case of fraud or abuse.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 01/01/2020

Date	Explanation & Changes
01/01/2020	• Reimbursement Policy created
07/01/2020	• Reimbursement Policy administrative updates
12/01/2023	• Reimbursement Policy updated to new template • Reimbursement Policy title changed from Timely Filing-Commercial to Timely Filing • Reimbursement Policy RM007 Claims Timely Filing – Medicare, combined with this policy
02/01/2024	• Reimbursement/Billing Policy updated to new policy template

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

Industry Standard Review