SAN FRANCISCO HEALTH PLAN

CL-06: Timely Filing Requirements for Providers and Claims Processing Guidelines

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: John Grgurina 5BD8B5B0FBA7424...	CEO	8/31/2020	Biennial Review

SFHP POLICY AND PROCEDURE

Timely Filing Requirements for Providers and Claims Processing Guidelines

Policy and Procedure Number:	CL-06
Department Owner:	Claims
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐ All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) processes all claims in accordance with the Medi-Cal contractual and regulatory requirements related to timeliness of provider billings. This policy also applies to Healthy Workers HMO claims.

PROCEDURE

Original (or initial) claims must be received by SFHP from providers within six (6) months following the month in which services were rendered to avoid penalty. If claims are not received in the prescribed time frames, penalties will be incurred and claims payments will either be reduced or denied according to Medi-Cal billing guidelines. This policy and procedure is in compliance with Welfare and Institution (W&I) Code 14115 and California Code of Regulations (CCR), Title 22, Sections 51008 Bills for Service, and 51008.5 Billing Procedures for Claims Delayed for Good Causes, which set forth the statutory authority requiring bills for Medi-Cal services to be submitted within six (6) months of the month of service. This requirement is referred to as the six-month billing limit. In addition, the regulations allow for submittal exceptions beyond the six-month billing limit. These guidelines apply to all lines of business through state and federal regulation and/or contractual stipulation.

Late Claim Submissions

Claims that are not received by SFHP within the six-month billing limit, and do not meet any of the allowable billing limit exceptions, will be reimbursed at a reduced rate or will be denied as follows:

Medi-Cal Timely Filing Restrictions and Penalties Grid

Claims Received between:	Pay at:
7th - 9th month	75% of payable amount
10th-12th month	50% of payable amount
After the 12th month	Zero payment

Timely Filing Requirements for Original Claim Submissions

When claims are not received by SFHP within the six-month billing limit, and do not meet any of the allowable billing limit exceptions, the claim payment is automatically reduced or denied by the system in accordance with the Medi-Cal six-month billing limit requirements. SFHP will deny claims for timely filing that are submitted beyond one year from the month after the dates of service or primary payer paid date.

Billing Limit Exceptions

W&I Code Section 14115 allows for the following four (4) exceptions to the six-month billing limit:

1) Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within the four (4) months after the month of service.
2) If a provider has submitted a bill to a liable third party, the provider has one (1) year after the month of service to submit the bill for payment.
3) If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services have been rendered.
4) The Director of Health Care Services finds the delay in submission of the bill was caused by circumstances beyond the control of the provider.

In Title 22, Section 51008.5 (a), the four (4) exceptions noted in the W&I Code Section 14115 are also noted as the four (4) circumstances that justify for the late submittal of a claim. This regulation also states that the circumstances causing late billing are beyond the control of the provider. The following reasons are unacceptable for claims being late:

- Negligence by employees
- Misunderstanding of or unfamiliarity with Medi-Cal guidelines
- Illness or absence of any employees trained to prepare bills
- Delays caused by the US Postal Service or any private delivery service

Delay reason codes are used on claims to designate approved reasons for late claim submission. These delay reasons also have time limits. Submittals beyond the six-month billing limit must indicate the allowed delay reasons and include the required documentation. The Delay reason codes descriptions, time limitations, and required documentation are listed in the document link to DHCS web document below:

Medi-Cal List of Delay Reasons

Delay reason codes should be listed in box 37A on UB-04 claim form and box 24C on the CMS-1500 form. Remarks area or attachments should accompany claim form to justify late submittal. Providers that do not meet any delay reasons when submitting claims during the seventh through twelfth month after the month of service should enter an "11" in box 18-24 (UB) or box 24C (CMS) of the claim form.

Providers must bill Medicare or the Other Health Coverage within one year of the month of service, claims related to these circumstances, together with the Medicare or Other Health Coverage Explanation of Benefits or Remittance Advice or denial letter, must be received by SFHP within 60 days of the other health carrier's resolution (payment/denial).

Reconsideration of Denied Claims or Claims with Payment Penalty Reductions

- When a claim that has been denied or its payment reduced, for not meeting the timely filing requirements, is resubmitted for reconsideration, the disputed claim will be processed through the Provider Dispute Resolution Mechanism described in SFHP's Policy and Procedure CL-07 Provider Dispute Resolution Workflow
- SFHP follows Title 28, Section 1300.71 guidelines governing timeframes for completing each step within the Provider Dispute Resolution process:

Step	Timeframe for Completion
Provider submits provider dispute	Within 365 days of the plan's or the plan's capitated provider's action or inaction
Acknowledge receipt of provider dispute	Electronically filed disputes – within 2 working days of receipt Paper disputes – within 15 working days of receipt
Resolve dispute and issue a written determination	Within 45 working days of receipt of a dispute or an amended dispute
Pay any outstanding monies determined to be due, together with all interest and penalties	Within 5 working days of date of resolution or Written Determination

Payment Due

Upon review of a disputed claim, SFHP may find that a claim is late due to one (1) of the billing limit exceptions and the documentation justifying the delay reason was met,

when the original claim was received or due to a SFHP processing error. In that case, the late billing is justified and the claim payment should not be denied or reduced.

SFHP shall pay any outstanding monies determined to be due, and all interest and penalties required by policy, CL-02, Interest Calculation for Late Payment of Claims, within five (5) working days of the issuance of the Determination letter.

The additional payment will include all interest and penalties required. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as set forth in section 1300.71(g) of Title 28.

For authorization request procedures, refer to the most recent Policies and Procedures for Utilization and Management Authorization Requests CO-22 Authorization Requests.

MONITORING

SFHP maintains a quality assurance program that regularly audits claim payments to ensure policies and procedures are followed and that claim payments are correct.

SFHP provides oversight of its delegated claim adjudication responsibilities through a monthly random claims audit and an annual oversight audit of its delegated medical groups to ensure compliance with laws and regulations of the California Code of Regulations (CCR) Title 22 and the DHCS contract.

In addition, Customer Service will log Provider calls related to "Timely Filing" issues in the Call Tracking system that is reviewed and responded to weekly by Claims Examiners.

DEFINITIONS

QNXT: The comprehensive health care management and administration software used by SFHP, which includes the claims processing application.

Timely Filing Per State Guidelines: The claims submission and timeliness guidelines as described in TITLE 22, SECTION 51008 (a) Except for good cause, bills for service provided pursuant to the Medi-Cal Program (Welfare and Institutions Code, Division 9, Part 3, Chapter 7), shall be received by the fiscal intermediary…not later than the sixth month following the month of service…

51008.5 (a) The Department, upon review of substantiating documentation received to justify good cause for late submittal of the claim, may receive and authorize the processing of late claims if the reason for delayed submission is due to one of the delay reasons allowed by regulations which are beyond the control of the provider.

AFFECTED DEPARTMENTS/PARTIES

Compliance & Regulatory Affairs
Finance
Health Services – Clinical Operations
ITS
Operations – Business Solutions
Operations – Claims
Operations – Customer Service
Operations – Provider Network Operations

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

1. CL-07: Provider Dispute Resolution Workflow
2. CO-28: Transportation Services and Authorization Requirements
3. CS-12: Non-Medical Transportation
4. DO-02: Oversight of Delegated Functions
5. PPI-01: Claims Quality Assurance Program

REVISION HISTORY

Effective Date: October 1, 2005; March 7, 2011
Revision Date(s): June 24, 2008; December 30, 2009; February 18, 2011; July 1, 2015; October 19, 2017; December 12, 2019, August 20, 2020

REFERENCES

1. MMCD Policy Letter 08-002 Payment of Invoices Beyond the Six-Month Billing Limit
2. CMS-1500 Submissions and Timeliness Instructions
3. UB-04 Submission and Timeliness Instructions
4. Re: Delay Reasons
5. CCR, Title 22, Division 3, Subdivision 1, Chapter 3, Article 1.3, Section 51008. Bills for Service.
6. CCR, Title 22, Division 3, Subdivision 1, Chapter 3, Article 1.3, Section 51008.5. Billing Procedures for Claims Delayed by Good Causes.