Medica Timely Filing and Late Claims Policy

Submissions

All original claims submissions must be received at the designated claims address no more than 180 days after the date of service or date of discharge for inpatient claims for *all* Medica and Medica SelectCare℠/ LaborCare® products except Medica Select Solution® and Medica Prime Solution®.

For Medica Select Solution and Medica Prime Solution, when Medicare is the payer, the timely filing limit is 180 days after the payment date on the explanation of Medicare benefits (EOMB) statement. When Medica is the payer, the timely filing limit is 180 days after the date of service or date of discharge for inpatient claims.

Exceptions

Following is a list of exceptions to the 180-day timely filing limit standard for all Medica and SelectCare/LaborCare products (except when Medicare is the payer for Medica Select Solution or Medica Prime Solution claims): Medica requires that claims, resubmissions and/or adjustments for these exceptions be received at the designated claims address within 18 months of the date of service or date of discharge for inpatient claims. In addition, SelectCare/LaborCare claims must be directed to the appropriate payer.

- Patient's date of birth less than one year before the date of service
- Duplicate payment for the same date of service
- Itemized billing for obstetric (OB) care and delivery
- Radiation treatment management services
- Member enrollment delays for COBRA continuation coverage (This is limited to 180 days after the member is enrolled. It should be further noted that it may take up to 60 days for complete enrollment.)

Adjustments (Medicare claims and all other claims, except for SelectCare/LaborCare claims)

Beginning on 1/1/2011, there is a 12-month limit for adjustments:

- If a claim is denied or rejected (one line or all lines), the clean claim must be resubmitted and received within 12 months of the date of the denial or rejection.
- If the claim was paid, and an adjustment to the payment is being requested, the request must be received within 12 months of the check date on the provider remittance advice (PRA).

  Note: For SelectCare/LaborCare claims, the 180-day time limit remains for adjustments to paid or denied claims.

Appeals for Failure to Obtain Prior Authorization

Beginning on 1/1/2014, there is a 60-day timeframe from the date of the denial on the provider remittance advice/electronic remittance advice (PRA/ERA) for submitting an appeal for lack of prior authorization when one is required by Medica.

Resubmissions (Medicare claims and all other claims)

- If a request for more information is received, the corrected claim or additional information must be resubmitted and received at the designated claims address *within 60 days of the date on the response letter from Medica*. If the corrected claim or additional information is *not* resubmitted within 60 days, *the pended claim will be denied* with reason code 054 ("Claim filed after time limit").

18-Month Final Filing Limit

Medica will not accept resubmissions or adjustments beyond 18 months after the date of service or date of discharge for inpatient claims (except when Medicare is the payer for a Medica Select Solution or a Medica Prime Solution claim and these resubmissions or adjustments meet the 180-day criteria listed above).

Terminated Self-Insured Groups

It is important to note that Medica is not liable for claims received after the run-out date for a self-insured employer group that has terminated coverage with Medica (even if submitted within the timely filing guidelines outlined in this document). These claims need to be submitted to the employer for consideration.

Late Claim Appeals

Medica understands that there are some circumstances that would warrant an appeal to this policy. If the provider would like to appeal a claim that is more than 180 days after the date of service but within 18 months of the date of service or date of discharge for inpatient claims, the provider can complete a Medica Claim Appeal Form (see "More information" section at end of this handout) in lieu of a Medica Adjustment Request Form and submit it for review with documentation indicating appropriate timely filing guidelines have been followed. This documentation must include notes about accounts receivable actions. For example, include notes documenting calls with the Medica Provider Service Center, notes documenting that the member was sent to collections within 180 days after date of service and/or a copy of the electronic acceptance report from your vendor. **Please note:** Appeals will only be processed if the claim was initially received within 180 days of the date of service. It should also be noted that documentation showing only claim submission will not be considered as valid documentation to waive timely filing.

If a provider disagrees with a denial after taking all appropriate steps to file the claim on time, contact the Medica Provider Service Center.

If the documentation supports the claim being filed after the time limit, the claim will be adjudicated and timely filing will be waived. If the documentation does not support the claim being filed after the time limit, the total claim or line will be denied.

Should the provider identify that something was missing in the supporting documentation, the provider can appeal by re-submitting the claim with the updated, clarified supporting documentation using the Medica Claim Appeal Form. If documentation now supports the claim being filed after the time limit, the claim will be adjudicated, and the timely filing will be waived. If the documentation still does not support the claim being filed after the time limit, the total claim or line will be denied.

Claims resubmitted more than 180 days after the denial or rejection (*without* documentation) will be denied.

Patient Not Identified as a Medica Member at the Time of Service

If the patient or another insurance company is initially identified as the payer, providers must attach supporting documentation that the claim was either referred to collections prior to 180 days from the date of service or date of discharge for inpatient claims, or be within 180 days from the other carrier's denial. Use of a Medica Claim Appeal form to submit these claims and the supporting documentation is required.

More information:

Medica Resources	
Topic	**Location**
Claim Appeal or Adjustment Request Form	medica.com at Providers>Administrative Resources>Claim Tools>Claim Appeal or Adjustment Request Form
Questions about the Medica Timely Filing and Late Claims Policy	Call the Medica Provider Service Center: 1-800-458-5512 **Hours of Service** Monday - Thursday from 8:30 a.m. - 5 p.m. Friday from 9 a.m. - 5 p.m. Central Time