

# PETTY MICHEL ASSOCIATES

## PRACTICE DEVELOPMENT

### Timely Filing

Every insurance company has a time window in which you can submit claims. If you file them later than the allowed time, you will be denied.

For most major insurance companies, including Medicare and Medicaid, the filing limit is one year from the date of service. If you are a *contracted* or in-network provider, such as for BC/BS or for ACN or HSM, the timely filing limit can be much shorter as specified in your provider agreement. It may be six months or even 90 days.

There should seldom be a time when claims are filed outside the filing limit. The only exceptions might be when you are dealing with a Medicare secondary and were appealing a denial prior to submitting to the secondary, or when an account was sent to work comp, then after much review was denied as not liable and now must be billed to health insurance. In these cases, you can appeal the claims, but you must call the insurance company and see what their appeal rights are. Medicare and Medicaid have specific appeal guidelines in their provider manuals, but other insurance companies vary.

If you actually were outside the timely filing limit, many insurance companies and most provider agreements prohibit you from pursuing the patient for the denied balance. It is also poor consumer relations to make the patient pay for your office's failure to submit the claim.

### Rebills on Claims Filed Timely

A frustrating problem when doing account follow-up is that most insurance companies only hold or "pend" claims in their system for 60 to 90 days. After that, if they are not paid or denied, they are deleted from their computers. A large insurance company may receive over 100,000 claims a day and their systems cannot hold that volume of pending claims. When you call to follow up, they will state, "we have no record in our system of having received that claim."

Now your only recourse is to rebill the claim. If it is outside their "timely filing", you will get a denial back. You should and must now appeal the denial. The first thing that you will need is proof that you actually did file the claim within the time window allowed.

### Proof of Timely Filing

For paper claims, you can reprint and attach the original claim, however some billing software will put today's date on the reprinted claim. Ask your software provider to walk you through reprinting a claim with the original date. There is no reason to photocopy all claims just in case you need to prove timely filing. For electronic claims, you should have the claims submittal report from your clearinghouse. These should always be kept (in electronic format) on your computer by date in a folder that is regularly backed-up.



## Special Circumstances

Occasionally, because of coordination of benefits or denials from the primary insurance or questions of liability, you will end up filing outside your agreed limit and get denied. In these cases, you have to call the insurance company and find out what their appeal guidelines are for late filing. I have not run across a company that does not have an appeal process for these rare circumstances, but it does vary from company to company.

## Prevention

There are always some times when you will fall outside a company's timely filing deadline. By reviewing your accounts receivable aging report every single month, by ensuring that your review all electronic submission reports (both from your clearinghouse and from the insurance company), and by setting up accounts correctly from the start, you minimize these problems.

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