

FILING DEADLINES FOR CLAIMS SUBMISSIONS

Policy Number: ADMINISTRATIVE 112.17 TO

Effective Date: November 1, 2017

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Related Policies
<ul style="list-style-type: none"> • Member Administrative Grievance & Appeal (Non Utilization Management) Process & Timeframes • Practitioner/Provider Administrative Claim Reconsideration and Appeal Process

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

PURPOSE

The purpose of this policy is to outline the timeframes for original claims submissions from providers and members, additional information, and appeals.

DEFINITIONS

Claim: A request for reimbursement for healthcare services filed with Oxford (or its vendors, as applicable).

Coordination of Benefits (COB): A provision used to establish the order in which plans pay claims when more than one source of coverage exists.

Explanation of Benefits (EOB): A detailed explanation of payment or denial of a claim made by an insurance carrier. An EOB may also be referred to as a remittance advice.

Non-Participating Provider: A provider who doesn't have a contract with Us to provide services to specific Oxford members (i.e., Freedom, Liberty, Metro, Garden State networks).

Participating Provider: A provider who has a contract with Oxford to provide services to specific Oxford members (i.e., Freedom, Liberty, Metro, Garden State networks).

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified, or accredited as required by state law.

Filing Deadlines for Original Claims

Original Claim Filing Deadlines for Providers

Provider Status	CT LOB	NJ LOB	NY LOB
Participating	90 days from the date of service (DOS)	180 days from the DOS	120 days from the DOS
Non-participating	180 days from the DOS		

Note:

- All New Jersey Non-Participating providers having rendered services to a New Jersey member without an assignment of benefits elected are not eligible to submit claims for payment.
- When the member’s line of business (LOB) state and the provider’s state conflict, the member’s LOB state governs the filing deadline.

Original Claim Filing Deadlines for Members

Claims Submitted by Member Enrolled on a:	For Reimbursement of:	Original Claim
NJ LOB	Services rendered by a Non-participating Provider	90 days from the DOS to submit proof of loss*
NY LOB		120 Days from the Date of Service
All Other LOBs		180 Days from the Date of Service

***Proof of loss** means that the member has not made an assignment to the provider and they are submitting the claims themselves. If the member is unable to submit the claim for services within 90 days, the member must submit the claim as soon as it is reasonably possible to do so.

Exceptions to Original Claim Deadlines for Providers and Members

- Network providers, certain plans and products and delegated arrangement contracts may have specific filing deadlines listed in their contract. When a conflict between this policy and the provider, plan/product, arrangement contract occurs, the provider, plan/product, arrangement contract governs the filing deadline.
- If coordination of benefits (COB) has caused a delay in the receipt of an explanation of benefits (EOB), letter of denial, etc. from the primary carrier, the provider will have 90 days from the date of the primary carrier EOB to submit the claim to Oxford.
- Inpatient hospital and facility claims utilize the discharge date as the starting point to determine the time frame for submission.
- Maternity related services can be submitted up to 90 days from the delivery date.
- If a previously denied authorization has been updated to an approved status, the date the appeal determination was made (as noted in the authorization) should be utilized as the starting point to determine the time frame for submission.
- Except as otherwise specified in the member's benefit plan document, failure to request reimbursement within the required time does not bar reimbursement if it was not reasonably possible to submit within the timeframe due to physical or mental incapacitation. However, the request must be made as soon as reasonably possible, as determined by Oxford.
- If a claim for a NY member is submitted past the filing deadline, a NY Participating Provider may request reconsideration of the claim if the participating provider has a historical pattern of timely submissions and the delay was due to an unusual occurrence (e.g., provider illness, provider's computer breakdown, fire, or flood).

Submission of Additional Information

Payment for services may be denied due to a lack of necessary, complete, or conflicting information. When Oxford denies a service requesting additional information, Commercial and Self-funded Members are given **45 days from the date of receipt of an Explanation of Benefits (EOB) or Remittance Advice** to submit the requested additional information, regardless of the provider’s status with the Oxford network.

Exception: Network providers, certain plans and products, and delegated arrangement contracts may have specific filing deadlines for the submission of additional information listed in their contract that conflict with this policy. When a conflict between this policy and the provider, plan/product, arrangement contract occurs the provider, plan/product, arrangement contract governs the filing deadline.

If the member wishes to submit the additional information outside of the allotted 45 days, he or she must submit an appeal of the initial decision.

Appeals

Guidelines and Processes

For appeals guidelines and processes, please refer to Oxford the following policies:

- [Member Administrative Grievance & Appeal \(Non Utilization Management\) Process & Timeframes](#)
- [Practitioner/Provider Administrative Claim Reconsideration and Appeal Process](#)

Proof of Timely Filing

In the event that a provider disputes the denial of an original claim for untimely filing, the provider must be able to show proof of submission within the filing deadline.

Note: If a claim for a NY member is submitted past the filing deadline, a NY Participating Provider may request reconsideration of the claim if the participating provider has a historical pattern of timely submissions and the delay was due to an unusual occurrence (e.g., provider illness, provider's computer breakdown, fire, or flood).

Electronic Submission

As proof of timely filing, the provider must submit two EDI acceptance reports. One report will show the date the batch was sent, number of claims sent, and the number of accepted claims vs. rejected claims. The rejected claims will show error details and the claims should be corrected and resent. The second report will show a listing of the claims by patient name that were received by the clearinghouse. These reports are supplied to Providers and facilities directly from the clearinghouse.

Note: Oxford will not accept a transmission report that only indicates the claim(s) were sent to the clearinghouse as proof of timely filing. Providers are responsible for checking their clearinghouse reports to ensure that the claim was accepted, and forwarded to Oxford.

Hardcopy Submission

As proof of timely filing, the provider must submit documentation showing that Oxford has received the hardcopy claim (receipt for certified letter, a copy of a screen print from the accounting software to show the date you submitted the claim, etc.).

REFERENCES

2017 UnitedHealthcare Provider Administrative Guide including Oxford Commercial Supplement available Jan. 1, 2017 found at: https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/UnitedHealthcare_Administrative_Guide_2017.pdf

ERISA 29 CFR s 2560.503-1 (f) (2) (iii).

NY Insurance Law ISC § 3224-a; 9(G), 9(H).

Oxford Member Certificates of Coverage.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
11/01/2017	<ul style="list-style-type: none">• Updated definitions:<ul style="list-style-type: none">○ Added definition of "non-participating provider"○ Revised definition of "participating provider" and "provider"• Revised guidelines for Filing Deadlines for Original Claims:<ul style="list-style-type: none"><i>Original Claim Filing Deadlines for Providers</i><ul style="list-style-type: none">○ Removed example scenarios○ Replaced language indicating "when the member's line of business (LOB) state and the provider's state conflict, the member's LOB <i>dictates</i> the filing guideline" with "when the member's LOB state and the provider's state conflict, the member's LOB <i>governs</i> the filing guideline"<i>Original Claim Filing Deadlines for Members</i><ul style="list-style-type: none">○ Removed example scenarios○ Modified notation to clarify <i>proof of loss means that the member has not made an assignment to the provider and they are submitting the claims themselves</i><i>Exceptions to Original Claim Deadlines for Providers and Members</i><ul style="list-style-type: none">○ Updated language to indicate:<ul style="list-style-type: none">▪ Network providers, certain plans and products and delegated arrangement contracts may have specific filing deadlines listed in their

Date	Action/Description
	<p>contract; when a conflict between this policy and the provider, plan/product, arrangement contract occurs, the provider, plan/product, arrangement contract governs the filing deadline</p> <ul style="list-style-type: none"> ▪ If coordination of benefits (COB) has caused a delay in the receipt of an explanation of benefits (EOB), letter of denial, etc., from the primary carrier, the provider will have 90 days from the date of the primary carrier EOB to submit the claim to Oxford ▪ Inpatient hospital and facility claims utilize the discharge date as the starting point to determine the time frame for submission ▪ Maternity related services can be submitted up to 90 days from the delivery date ▪ If a previously denied authorization has been updated to an approved status, the date the appeal determination was made (as noted in the authorization) should be utilized as the starting point to determine the time frame for submission ▪ Except as otherwise specified in the member's benefit plan document, failure to request reimbursement within the required time does not bar reimbursement if it was not reasonably possible to submit within the timeframe due to physical or mental incapacitation; however, the request must be made as soon as reasonably possible, as determined by Oxford ▪ If a claim for a NY member is submitted past the filing deadline, a NY Participating Provider may request reconsideration of the claim if the participating provider has a historical pattern of timely submissions and the delay was due to an unusual occurrence (e.g., provider illness, provider's computer breakdown, fire, or flood) <ul style="list-style-type: none"> • Revised guidelines for Submission of Additional Information; updated exception language to indicate: <ul style="list-style-type: none"> ○ Network providers, certain plans and products, and delegated arrangement contracts may have specific filing deadlines for the submission of additional information listed in their contract that conflict with this policy; when a conflict between this policy and the provider, plan/product, arrangement contract occurs the provider, plan/product, arrangement contract governs the filing deadline • Revised guidelines for Appeals: <ul style="list-style-type: none"> <i>Proof of Timely Filing</i> <ul style="list-style-type: none"> ○ Updated notation to indicate: <ul style="list-style-type: none"> ▪ If a claim for a NY member is submitted past the filing deadline, a NY Participating Provider may request reconsideration of the claim if the participating provider has a historical pattern of timely submissions and the delay was due to an unusual occurrence (e.g., provider illness, provider's computer breakdown, fire, or flood) ○ Updated guidelines for Electronic Submission; added language to clarify: <ul style="list-style-type: none"> ▪ As <i>proof of timely filing</i>, the provider must submit two EDI acceptance reports ▪ The <i>second</i> report will show a listing of the claims by patient name that were received by the clearinghouse ▪ Oxford will not accept a transmission report that only indicates the claim(s) were sent to the clearinghouse <i>as proof of timely filing</i> ○ Updated guidelines for Hardcopy Submission; added language to clarify: <ul style="list-style-type: none"> ▪ As <i>proof of timely filing</i>, the provider must submit documentation showing that Oxford has received the hardcopy claim (receipt for certified letter, a copy of a screen print from the accounting software to show the date you submitted the claim, etc.) • Updated supporting information to reflect the most current references • Archived previous policy version ADMINISTRATIVE 112.16 TO