Medica Timely Filing and Late Claims Policy

Submissions
All original claim submissions for all products where Medica is the primary payer 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. When Medica is the secondary payer, the timely filing limit is 180 days from the payment date on the explanation of the primary carrier's remittance advice and/or the member's explanation of benefits.

Exceptions
Following is a list of exceptions to the 180-day timely filing limit standard for all Medica products. 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.

- Patient's date of birth less than one year before the 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
An Adjustment is a transaction that is made to correct a claim after it has been processed (ex: adding a modifier, correcting a CPT code). There is a 12-month limit for adjustments:

- If an adjustment to the claim is requested, the request must be received within 12 months of the processing date on the provider remittance advice (PRA).

Appeals
An Appeal is a request to reconsider an initial determination. To ensure the appeal is considered and processed appropriately, include rationale and supporting documentation as to why the claim should be reconsidered.

- If a provider initiated appeal is being requested (charges are denied as provider liability), the request must be received within 12 months of the check date on the provider remittance advice (PRA).
- If a provider is appealing on behalf of the member (charges are denied as member liability), follow timelines in the member's plan document along with state/federal regulations

*** For additional details on Adjustments and Appeals, refer to the Claim Adjustment/Appeal Guidelines located in Medica's Administrative Manual.*

Appeals for Failure to Obtain Prior Authorization
There is a 60-day timeframe from the date of the denial on the PRA for submitting an appeal for lack of prior authorization when one is required by Medica. Refer to Prior Authorization and Notification Requirements for additional details.

Appeals Due to a Timely Filing Denial
Medica understands that there are some circumstances that could 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 Adjustment or Appeal 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.

- If the documentation provided supports the claim being filed after the time limit, the claim will be readjudicated and timely filing will be waived.
- If the claim is still denied after supporting documentation has been submitted, contact the Medica Provider Service Center. Additional documentation may be required and, depending on the documentation, timely filing may be waived**.**

Resubmissions
If Medica requests additional information, it must be resubmitted to the designated claims address *within 60 days of the date on the response letter from Medica*. If the information is *not* resubmitted within 60 days, *the pended claim will be denied* as "Claim filed after time limit".

Terminated Self-Insured Groups
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.

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 patient was held liable 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 Adjustment or Appeal Request Form to submit these claims and the supporting documentation is required.

More information

Medica Resources:	
Topic	**Location**
Claim Adjustment or Appeal 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 at 1-800-458-5512 **Hours of Service** Monday – Friday, 7 a.m. to 5 p.m., Central Time *Closed Mondays 8 – 9 a.m. for training*

Rev 6/2021