

# Timely Filing Payment Policy

## Policy

The filing limit for claim submission to the Plan is 120 days from the date of service. If the contract with the Plan specifies a different time limit, that limit will apply. Follow the guidelines outlined in the Plan Provider Manual, Claims Guidelines and Submission sections.

### Adjustments and Provider Appeals:

All adjustment requests and provider appeals must be received in writing within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS) in order to be considered for review. Follow the guidelines outlined in the Plan Provider Manual, Adjustments and Provider Appeals section.

### Prompt Payment:

The Plan's policy is to make payment or notify the provider in writing of the reason for nonpayment within the appropriate timeframes as dictated by CMS, Massachusetts Division of Insurance, the Federal Division of the Department of Labor, and/or the prompt payment clause stated in the Managed Care Act or other applicable regulations. For fully insured products, a legislated interest payment will be made by the Plan for those claims paid outside of the mandates.

## Definitions

A claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment is considered a "clean claim".

## Billing/coding guidelines

Follow the guidelines as outlined in the Plan *Provider Manual*, Claims Submission section.

## Place of service

This policy applies to services rendered in all settings.

## Policy history

Origination date:	02/13/2002
Previous revision date(s):	05/14/03, 04/28/04, 04/13/05, 04/12/06, 3/14/07 07/01/2010 - Moved to new template; expanded to include information on claim, adjustment, and appeal time submission requirements. 01/01/2016 - Annual review and updated to new Plan template.
Connection date & details:	November 2016 – Annual review. January 2018 – Annual Review, no updates. January 2019 – Annual Review, no updates. January 2020 – Annual Review, no updates. April 2021 – Annual review, no updates.

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely*

*verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*