HAVE YOU EVER FOLLOWED UP WITH AN INSURANCE COMPANY ON A CLAIM ONLY TO BE INFORMED…WE DON'T SHOW A RECORD OF RECEIVING YOUR CLAIM?

A frustrating problem when doing account follow-up is that most insurance companies only hold or "pend" claims in their system for 30 to 60 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 then state, "we have no record in our system of having received that claim."

What do you do when your claim is lost, not received, or perhaps deleted within the insurance company's system – when you know you mailed the claim in a timely manner?

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.

HOW TO FILE AN APPEAL – INCLUDING EXAMPLE APPEAL LETTERS (S)

What do you do when some of your claims *are* returned because of timely filing?

If you've made sure that you *have* really sent your claims all within their timely filing limits, then you can **send a timely filing appeal** (even up to 2 or 3 times), and get your claims paid!

SENDING CLAIMS IN A TIMELY MANNER

To send a timely filing appeal, you have to have **evidence** to support your statement that the claim was sent within the timely filing deadline. This means two things:

1. That you actually have to send all of your claims within the timely filing deadline, and
2. That you have documents to support the fact that you sent your claims within the timely filing deadline.

Typically, when you send claims through any type of practice management system, an internal report is generated. This says which claims were sent and on which day.

The clearinghouse that you use may also generate reports that state which claims went out on which days, and to which insurance companies they were sent. **The clearinghouse reports, as well as your internal claims reports, can both be sent as proof of timely filing.**

WHEN YOU GET A TIMELY FILING DENIAL

Let's say that you have sent a batch of claims, checked them at the clearinghouse, and they have all gone out correctly.

Unfortunately, however, **some claims simply get lost, or the insurance company claims they don't have a record of receiving.** This means that even though you sent them to the right place and within the right time frame, they are lost in the system and you never get a response from the insurance company.

By the time you have noticed and resent the claim, it was past the timely filing deadline, and **your claim was denied for timely filing.**

Usually, the entire claim will be completely denied, with a reason stating something like: *"This claim has been received past the timely filing deadline. You may not bill the patient for this balance."*

This means that you have to write off the claim as denied for timely filing.

Unless...

You have proof that **you really did send the claim within the timely filing deadline** in the first place.

SENDING A TIMELY FILING APPEAL

When you send claims via your practice management system, make sure you print out your claims report, which says which claims went out on which days. You can use this report to support your timely filing appeal.

Once you receive a denial for timely filing, there is an **important process to follow to send a timely filing appeal:**

1. The first thing you have to do is **make sure that you really did send the claim within the timeframe.**

   If you didn't, then you have no reason for the appeal, and you cannot appeal the claim. This means you have to write it off as a direct loss to your office!

2. If, on the other hand, you really did send the claim within the timeframe, the next thing to do is **make a copy of the report which says that you sent the claim, including the date** that the claim was sent.

   - If this report doesn't have any type of date on it, you can't use it for your timely filing appeal.
   - Once you have your claims report, which contains the claims that were denied for timely filing, you can use this page as a means of support for your timely filing appeal.

3. The next thing you need to do is **write an appeal letter, which explains to the insurance company that you really did send the claim before the timely filing deadline,** and that they need to pay the claim.

4. After you have printed out your appeal letter, you'll need to **print out a paper version of the claim that was denied on an official CMS-1500 claim form**. This is, so the insurance company knows the specifics of the claim, and so that they can process it directly.
5. You may also want to **make a copy of the Remittance Advice or EOB,** on which your claim was denied for timely filing.

    - Sometimes it helps to send this along with the appeal so that the insurance company can locate your claim. ***The easier it is for the insurance company to process your appeal, the more likely it is that they will pay it!***

6. Gather all of your paperwork together, with the appeal letter on top, and **send it to the claims processing department of the insurance company**.

    Many, but not all, insurance companies have specific appeals processing departments, to which to have to mail appeals directly, so make sure you are sending the appeal of your claim to the right address. *If you don't send your appeal to the right address, it won't be processed correctly!*

Most appeals take anywhere from 30 to 45 days to process, so make sure you **keep a copy of the appeal for your own records** and check the appeal in 30-45 days to see if it has been paid.

If, after 45 days, you have received no response from the insurance company, you will need to call the claims department to make sure they have received the appeal and are processing it for payment.

One of the things that came out of our research was to file an appeal with the insurance company. Every company has a process where you can file an appeal, two, sometimes three times. Too many companies give up on the first appeal. However, this step works for many, so **it's too important not to skip!**

SAMPLE OF A TIMELY FILING APPEAL LETTER (#1)

The following is a simple sample timely filing appeal letter:

(Your practice name and address)

(Insurance Company name and address)

(Date of appeal)

Patient Name:

Patient Identification Number:

Date of service:

Total claim amount:

To Whom It May Concern;

The above claim has been denied due to timely filing. However, this claim was originally sent within the timely filing limits. Please see attached claims report, stating that this claim was originally sent (electronically/paper) to the correct insurance company on (date). This date was within the timely filing limits, and the claim should have been paid upon receipt. It has been incorrectly denied due to timely filing.

Please see all attached documentation in support of this appeal. If you have any questions or concerns, please feel free to contact me at the below contact number.

Thank you for your prompt attention to this matter.

Sincerely,

(Your name)

(Your title)

(Your contact phone number)

SAMPLE OF A TIMELY FILING APPEAL LETTER (#2)

Name of Insurance Company
Address (get an address for appeals if it exists)

Re: Appeal of Denial for Timely Filing

Patient Name:
Group Number: DOS:
Subscriber No: Reference No.:
(etc. – get this information from the denial)

We are appealing the denial of claims for (patient name) and request that these claims be reviewed and paid.

On (original submission date) we submitted claims for services rendered to the above patient. This was well within your timely filing deadline.

The promptly and properly submitted claims were neither paid nor denied by your company. On (date of resubmission) we resubmitted the claims for consideration. On (date of denial) we received a denial of the claims for “timely filing”. Please see the attached EOB from your company.

I have attached copies of the original claims showing the date they were printed. Our office policy is to send all claims on the date they are produced. The printed date is the date of submission and is well within your deadline. (or) I have attached a copy of our Claims Submittal Report provided by our electronic claims clearinghouse showing that the original submission date was well within your deadline.

We respectfully request that these claims be promptly processed and that are office is paid for the services rendered to your subscriber as allowed by the State prompt payment regulations. If this claim is further denied, we intend to then file a complaint with the Office of the Insurance Commissionaire.

If you have any questions, you are welcome to contact me directly at (123) 456-7890.

Sincerely,

Your Name

CONTACT YOUR STATE'S INSURANCE COMMISSIONER

The next step if you can't find a resolution to your medical claim billing dispute is to loop in your state regulators Many providers/billers have no idea that State Insurance Commissioners even exist, but basically, they are the government agency in charge of making sure insurance providers are complying with the law. They work with both the provider and the insurance company. They know all the laws and regulations! ,

- Each jurisdiction sets its regulations in regards to responding to a claim and settlement time allowed after a claim is filed. In most jurisdictions, response or acknowledgement of a claim is required in 30 days of notification, unless extenuating circumstances apply.
- You will typically need to fill out an official complaint form, and you can then attach your own documentation to support.

DISCLAIMER

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