



Network Notification

Date: August 25, 2010

Number: OH-P-2010-21b

To: Ohio Providers

From: CareSource

Subject: Timely Filing Revisions

Effective Date: September 1, 2010

CareSource is revising its timely filing requirements for claims, now giving providers 365 days.

As a result of expanding the window to file claims, it impacts the timelines for filing claims, appeals, medical necessity and retrospective utilization determinations.

This Network Notification is intended to add clarity to terms normally used as they relate to claim and clinical appeals, claim corrections and claim reconsiderations.

Conditions of Timely Filing:

- The filing period will be counted from the date of service or discharge date, whichever is later.
- All appeals and retrospective utilization determination requests submitted and received by CareSource's timely filing end date will be considered.
- Appeals having gone through the formal appeals process are deemed to be final.

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Term	Definition	Previous Window	New Window
Clean Claim	As defined by OAC 5101:3-1-19.7, a claim that can be processed without obtaining additional information from the provider of the service or from a third party.	180 days	365 days from date of service or date of discharge
Medical Necessity Appeals With or Without a Claim	An appeal in which the provider was denied authorization or reimbursement. The appeal request may be submitted by the provider with or without the related claim attached.	90 days	180 days from date of service, date of discharge or date of denial if service was not yet rendered
Coordination of Benefit Claims	Claims received from providers whereby CareSource is the secondary payer. The timeline allows the provider sufficient time to bill the primary payer, receive the appropriate rejections and submit the same to CareSource for processing. The specific COB billing practices are documented elsewhere.	90 days	365 days from date of service or date of discharge, or 90 days from the other carrier's EOB or whichever is later
Claim Paid Incorrectly	A claim in which CareSource made an error in how the claim was adjudicated. The provider should identify the error and submit an appeal via the CareSource provider portal.	90 days	365 days from date of service or date of discharge
Corrected Claim	A claim in which the provider made an error. The claim should be identified as a "Corrected Claim" and resubmitted to CareSource for processing.	90 days	365 days from date of service or date of discharge
Claim Appeal	Appeal of a denied claim in which the provider billed a service and payment was denied or reduced and the provider disagrees with the decision. The provider may submit a request to appeal the case citing certain references or providing any documentation to justify the reimbursement request.	90 days	365 days from date of service or date of discharge
Retrospective Utilization Review Request	A request for a utilization determination after service has been delivered. It may or may not have been previously submitted on a claim.	90 days	180 days from date of service or date of discharge