Policy Title: Claims Submission and Timely Filing Guidelines	**Policy Number:** OPC23 **Revision:** D
Department: Operations	**Sub-Department:** Claims
Applies to Product Lines: ☐Medicaid ☐Children's Health Insurance Plan ☒Health Insurance Exchange ☒Medicare ☒USFHP ☐Commercial Insured ☐Non Insured Business	
Origination/Effective Date: 09/28/2017	
Reviewed Date(s):	**Revision Date(s):** 12/27/2018, 03/25/2020, 03/24/2021, 02/23/2022

SCOPE:

Outlines CHRISTUS Health Plan Claims Submission and Timely Filing guidelines.

DEFINITIONS AND ACRONYMS:

- **Centers for Medicare and Medicaid Services (CMS)**
- **Claim Receipt Date -** Unless otherwise agreed to in the provider's contract, the receipt date for claims, electronic and paper, is the date the claim is received into CHRISTUS Health Plan's claims clearing house system.
- **Clean Claim -** A claim submitted by a provider for medical health care services rendered to a Member with the required data elements as set forth in state or federal regulations for claims submission, whichever applies.
- **General Billing Guidelines -** Are those standards and rules set by Medicare and TRICARE, and any state regulations for the appropriate billing of claims.
- **Louisiana Department of Insurance (LDI)**
- **New Mexico Office of Superintendent of Insurance (NM OSI)**
- **Texas Department of Insurance (TDI)**
- **Uniformed Services Family Health Plan (USFHP)**

POLICY:

Claims Submission:

Electronic Claims:
Electronic claims must be submitted via the CHRISTUS Health Plan clearinghouse. Clearing house information is as follows:

US Family Health Plan –

- Clearinghouse: Change Healthcare
  - Payer ID: 90551
- Clearinghouse: Availity
  - Payer ID: USFHP

CHRISTUS Health Plan Medicare Advantage -

- Clearinghouse: Change Healthcare

- Payer ID: 10629

CHRISTUS Health Plan New Mexico Health Insurance Exchange

- Clearinghouse: Change Healthcare
  - Payer ID: 21062

CHRISTUS Health Plan Texas and Louisiana Health Insurance Exchange

- Clearinghouse: Change Healthcare
  - Payer ID: 52106

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- Clearinghouse: Change Healthcare
  - Payer ID: 45210

***Acknowledgement Response Advice* – retain the 'accepted' or 'rejected' notice generated from the clearinghouse for claims submitted either directly to them or through a separate clearinghouse in those instances where proof of timely filing may be required.

*5010 - Is the current version and transaction standards for HIPPA compliant EDI to send and receive claims and all other HIPPA adopted electronic transactions

*837i – The standard format transmitting healthcare claims electronically. It is used for electronic submission of institutional claims

*837p – The standard format for transmitting healthcare claims electronically. It is used for electronic submission of professional claims.

Paper Claims:
Paper claims must be filed using the required form and data elements for physicians, non-institutional, or institutional providers on the CMS-1500 (02.12) or CMS-1450, whichever is appropriate claim form for Medicare Claims.

Paper claims must be sent to the appropriate address for the Member plan as shown below.

US Family Health Plan
PO Box 981696
El Paso, TX 79998-1696

CHP Medicare Advantage
PO Box 981651
El Paso, TX 79998-1651

CHP New Mexico Health Insurance Exchange
PO Box 981636
El Paso, TX 79998-1636

CHP NCHD
PO Box 981638
El Paso, TX 79998-1638

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CHP Texas and Louisiana Health Insurance Exchange
PO Box 981654
El Paso, TX 79998-1654

Claims Timely Filing:

Unless otherwise agreed upon in a provider's contract, a provider must submit a claim to CHRISTUS Health Plan as outlined below. Claims not received before the expiration of applicable timely filing deadline will be denied.

For **all** products, the following guidelines are used to determine the start date for the timely filing period.

- Non- Institutional/Professional:
  - Use the line item "From" date of service to determine timeliness for non-institutional/professional claim line items that contain date spans.
- Inpatient Institutional:
  - Use the "Through" date on an institutional claim as the date of service for claims that contain span dates (i.e., "From" and "Through" dates) to determine timeliness
- Outpatient Institutional:
  - Use the line item date of service to determine timeliness for Outpatient Institutional claim line items.

US Family Health Plan –

- Non- Institutional/Professional: 365 calendar days from the date of service
- Institutional: 365 calendar days from date of

discharge **CHRISTUS Health Plan Medicare Advantage -**

- Non- Institutional/Professional: 365 calendar days from the date of service
- Institutional: 365 calendar days from date of discharge

CHRISTUS Health Plan New Mexico Health Insurance Exchange

- Non- Institutional/Professional: 120 calendar days from the date of service
- Institutional: 120 calendar days from date of discharge

CHRISTUS Health Plan Texas Health Insurance Exchange

- Non- Institutional/Professional: 95 calendar days from the date of service
- Institutional: 95 calendar days from date of discharge

CHRISTUS Health Plan Louisiana Health Insurance Exchange Paper Claims:

  - Non- Institutional/Professional: 45 calendar days from the date of service
  - Institutional: 45 calendar days from date of discharge

- **Electronic Claims:**
  - Non- Institutional/Professional: 30 calendar days from the date of service

Institutional: 30 calendar days from date of discharge

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- Non- Institutional/Professional: 120 calendar days from the date of service
- Institutional: 120 calendar days from date of discharge

** Special requirement -- for February 29th date of service: Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed.

Coordination of Benefits

Claims submitted requiring coordination of benefits should be submitted within 120 days of receipt of the primary payer's determination and should be accompanied by the primary payers Explanation of Payment.

Claims submitted that exceed the timely filing deadline, or that are not accompanied by the explanation of payment, will be denied.

**CHRISTUS Health Plan reserves the right to audit all claims filed to ensure accuracy and compliance with the health plan standards and policies.

REFERENCES:

* www.cms.gov – Medicare Claims Processing Manual, Chapter 1, Subsection 70
  Medicare Claims Processing Manual, Chapter 25& 26 42 C.F.R. § 422.520(a)(3); Medicare Managed Care Manual Ch. 11 – Section 100.2 and Ch. 13 – Section 40.1
* www.tricare.mil – Tricare Operations Manual, Chapter 8 Claims Filing Deadline
* www.tdi.texas.gov – Texas Department of Insurance, 28 TAC §§21.2806
* www.ldi.la.gob – Louisiana Department of Insurance, Title 22 §1832 and §1833

RELATED DOCUMENTS:

None

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	09/28/2017	Initial release.	Quality Improvement Committee
A	12/13/2018	Yearly review. Added NCHD to payer ID and claim mailing address. Changed CHP to CHRISTUS Health Plan.	Executive Leadership
B	03/25/2020	Yearly review. Changed title. Removed unnecessary verbiage. Added Louisiana payer information.	Executive Leadership
C	03/24/2021	Yearly review. No change to policy content.	Executive Leadership
D	02/23/2022	Yearly review. No change to policy content.	Executive Leadership