Coordinated Care Organization Timely Filing Guidance

The Oregon Health Authority (OHA) has become aware of a possible issue surrounding the coordinated care organization (CCO) contract language in Section 5(b) Exhibit B Part 8 which states pursuant to Oregon Administrative Rule (OAR) 410-141-3565 (previously 410-141-3420):

> *Contractor shall require Providers to submit all billings for Members to Contractor within four months of the Date of Service. However, Providers may, if necessary, submit its billings to Contractor within twelve (12) months from the date of Service under the following circumstances:*
> *(1) Billing is delayed due to retroactive deletions or enrollments;*
> *(2) Pregnancy of member;*
> *(3) Medicare is the primary payer, unless Contractor is responsible for Medicare reimbursement;*
> *(4) Cases involving Third-Party Resources; or*
> *(5) Other cases that delay the initial billing to Contractor, unless the delay was due to the Provider's failure to verify a Member's eligibility;*

The fee-for-service (FFS) rule related to timely filing is found in OAR 410-120-1300 and states in part that Medicaid FFS-only claims must be filed within 12 months of the date of service, and an additional 6 months is allowed for claims correction.

Clarification:

The contract language and OAR 410-141-3565 apply to the timely filing of initial claim submissions within four months of the date of service. The requirement only pertains to the initial claim filing and the four-month timeframe is not intended to include the resubmission of denied claims for correction. The timeframe for correction of claims should occur outside of the four-month timeframe detailed in rule and contract.

For consideration:

OHA is considering rewriting the rules and contract language during the 2021 restatement period to include specific guidance surrounding time frames allowed for resubmission of claims after the four-month initial submission period.

To inform OHA's understanding of the issue, we will initiate a review of CCO policies and provider manuals to understand the timeframe allotted by each CCO for corrected claim resubmissions. OHA will attempt to gather the information but may need to reach out to individual CCOs if we are unable to locate the most up-to-date information.

OHA strongly encourages CCOs to consider reprocessing any claims submitted within the four-month window that have been denied because the claim was resubmitted for correction outside of this timeframe.