Timely Filing

Policy and Purpose

"Timely filing" is an important requirement in the TennCare program. In order for provider claims to be paid, they must be submitted within certain periods of time. Claims that are submitted outside the appropriate period of time will be automatically denied as not having been timely filed.

Timely filing requirements are different for different payers. The purpose of this policy is to summarize the timely filing requirements for all types of claims for which Federal Financial Participation (FFP) is available. TennCare cannot pay claims for services for which there is no FFP.[1]

The chart below provides a general overview of the timely filing requirements according to payer type. The sections below provide more detail.

Payer	Timely Filing Limit	Exception for Retroactive Eligibility (See Section 1)	Exception for Third Party Liability (See Section 2)
Managed Care Organization (MCO)	120 calendar days	Yes	Yes
Pharmacy Benefits Manager (PBM)	1 year	Yes	Yes
Dental Benefits Manager (DBM)	120 calendar days	Yes	Yes
TennCare[2]	1 year	Yes	Yes

NOTE: Although the timelines described in the table above are generally applicable, an exception exists for claims involving Medicaid services delivered in schools. The timely filing limit for submission of a school-based claim to a TennCare MCO for physical therapy, occupational therapy, speech therapy, and audiology services when included in an Individualized Education Program (IEP) is one year from the date of service.

Generally, timely filing is determined by the **date of service** on the claim. However, there are circumstances in which other methods are utilized to determine timely filing. A list of the circumstances not otherwise described in this policy that may affect timely filing deadlines is located in the TennCare rules at 1200-13-13-.08(12) and 1200-13-14-.08(12).

[1] TennCare Rules 1200-13-13-.10(1)(c) and 1200-13-14-.10(1)(c).

[2] TennCare pays some types of claims on a fee-for-service (FFS) basis. These include claims for services provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), claims for services provided under one of TennCare's three Home and Community Based Services (HCBS) waivers for persons with intellectual disabilities, claims for certain services provided by the Department of Children's Services (DCS), and Medicare crossover claims.

With an outpatient service like a physician office visit, the date of service is clear. However, other services may span a period of time. An example is an inpatient hospital stay.

Services that span a period of time are considered to have a "from" date (the actual date that the service began) and a "to" date (the actual date that the service ended). An inpatient hospitalization, as an example, would have a "from" date (the date of admission) and a "to" date (the date of discharge).

The dates of service that are used to start the timely filing "clock" are described below.

Type of Service	Start Date for the Timely Filing Clock
Service that takes place on a single day in time	Date of service
Medicare crossover claims with service dates that span a period of time (e.g., inpatient hospitalization)	"To" date
Medicare crossover claims with physician or supplier service that spans a period of time (e.g., DME)	"To" date
All other TennCare fee-for-service claims (e.g., DIDD waiver-related services, ICF/IID services, DCS claims)	"From" date

Medicare crossover claims are usually sent to TennCare by the Medicare Coordination of Benefits Contractor and Dual Special Needs Plans. However, there are occasions when providers may submit Medicare crossover claims directly to TennCare utilizing the appropriate paper claim form.

If the Medicare claim did not automatically cross over to TennCare, and the claim is outside of the one-year timely filing limit, the provider has six months from the date he was notified by Medicare of payment or denial of his claim to submit his request for crossover payment directly to TennCare. Instructions for submitting a claim in this manner may be found in the "Crossover Reprocess Request" sections of the provider billing manuals available online at https://www.tn.gov/tenncare/providers/claims-appeals-provider-complaints/medicare-medicaid-crossover-claims.html.

Note that retroactive eligibility and third party liability may alter the "start date" for the timely filing clock. See Sections 1 and 2 below.

Section 1. Retroactive Eligibility

Sometimes persons are enrolled in TennCare with a retroactive eligibility date. One example would be people who are determined to be eligible for Supplemental Security Income (SSI). Those eligibility determinations are conducted by the Social Security Administration, rather than the State, and once a person is found eligible, his eligibility goes back to his date of application. Another example is pregnant women or children. Once individuals in these groups are determined to be eligible for TennCare, their eligibility goes back three months prior to their date of application.

Providers may have delivered services to a person while his eligibility was pending. If the person becomes retroactively eligible, these providers may bill TennCare or the Managed Care Contractors (as applicable) for the covered services they provided during the period when eligibility was pending. In these situations, the start date for the timely filing clock will be the date shown below rather than the date that the service was delivered.

Payer	Start Date When Retroactive Eligibility is a Factor
MCO	The date that TennCare notifies the MCO of the individual's enrollment
PBM	The date that TennCare notifies the PBM of the individual's enrollment
DBM	The date that TennCare notifies the DBM of the individual's enrollment
TennCare	The date that the enrollee's record is loaded into the TennCare system

Example:

- On **March 18**, Paul applied for SSI.
- On **April 5,** Dr. Jones treated Paul for a sprained wrist.
- On **September 16**, TennCare learned that Paul was eligible for SSI and therefore TennCare, and that his eligibility was retroactive to **March 18**.
- On **September 17,** TennCare forwarded Paul's enrollment information to his MCO.

In this example, Dr. Jones has 120 days to file his claim with his MCO. However, the start date for the 120-day period is **September 17** (the date that his MCO learned of Paul's enrollment) rather than **April 5** (the date that Dr. Jones actually treated Paul). Dr. Jones is not penalized for the time when Paul's eligibility status was unknown.

Section 2. Third Party Liability

When there is a case regarding coordination of benefits or a subrogation case that a provider is pursuing for payment from a third party, the start date of the timely filing clock is the date that the third party documents resolution of the claim.

Offices of Primary Responsibility

Information Systems (Crossover Claims Unit)
Fiscal Office (Accounting Unit)
Managed Care Operations
Pharmacy Office
Dental Office

References

42 CFR § 447.45(d)
https://www.ecfr.gov/cgi-bin/text-idx?SID=692aee5de2f36b7de70a3b763f1d7cec&mc=true&node=se42.4.447_145&rgn=div8

TennCare Rules 1200-13-13-.08(12) and 1200-13-14-.08(12)
https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm

MCO Contractor Risk Agreement
https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf

DBM Contract
https://www.tn.gov/content/dam/tn/tenncare/documents2/DentaQuest59802.pdf

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