17.3 Time Frames for Claim Submission, Adjudication and Payment

Timely Claim Submission

Providers should submit all claims within thirty (30) days of the date of service for prompt adjudication and payment. However, claims for services that are submitted later than the time period set forth in the provider's agreement with Healthfirst will not be paid except under certain circumstances. In no event will Healthfirst pay claims submitted more than one hundred eighty (180) days after the date of service. Please refer to Section 17.2 for electronic and paper submission of claims.

Late Claim Submission

In certain circumstances, Healthfirst will process claims submitted after the time period required under the provider's agreement with Healthfirst. Please note that "unclean" claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time period required. The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider's control.

Reason for Delay	Time Frame for Submission
Litigation involving payment of the claim	Within sixty (60) calendar days from the time the submission came within the provider's control
Medicare or other third party processing delays affecting the claim	Within sixty (60) calendar days from the time the submission came within the provider's control
Original claim rejected or denied due to a reason unrelated to the 180-day rule	Within sixty (60) calendar days of the date of notification (submit with original EOP)
Administrative delay (enrollment process, rate changes) by NYSDOH or other State agencies	No time frame
Delay in member eligibility determination	Within sixty (60) days from the time of notification of eligibility (submit with documentation substantiating the delay)
PRO denial/reversal	No time frame
Member's enrollment with Healthfirst was not known on the date of service	Within sixty (60) days from the time the member's enrollment is verified. Providers much make diligent attempts to determine the member's coverage with Healthfirst

The Insurance Carrier Rejection Report—R059/RPT-11 (refer to Section 17.2)—may be used to substantiate timely filing to Healthfirst.

Healthfirst adjudicates and pays all claims for its Medicaid, FHP, CHP, and commercial plans according to Section 3224-a of the New York State Insurance Law, also known as New York's "prompt pay" law. Healthfirst adjudicates and pays all claims for its Medicare lines of business pursuant to Section 3224-a of the New York State Insurance Law, except that the applicable prompt pay interest rate shall be that applicable to Medicare fee for service interest rate. Out of Network Medicare claims are adjudicated pursuant to the applicable regulations governing Medicare Advantage Plans.

Grace Period Impact to Commercial and Leaf Plan Providers

Provider payment is subject to member's insurance coverage status; refer to Section 4.4: Eligibility Verification. Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period. Claims submitted during days 31–90 of the member's grace period will not be subject to prompt pay provisions until the member pays their premium in full. Providers are not permitted to balance-bill members during days 31–90 of their grace period. If the member's premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If

the member premium is not paid in full by the end of the grace period, claims incurred during days 31–90 of the grace period will be denied.