EmblemHealth®

Keep Your Bottom Line Healthy

Avoid claims timely filing denials and common billing pitfalls

Timely Filing Limits

Participating Medical, Facility, and Hospital Providers

Unless otherwise specified by the applicable participation agreement or the member's self-funded plan's provisions, new claims must be received within 120 days of the:

- Date-of-service.
- Primary carrier's explanation of payment (EOP) issue date when EmblemHealth is the secondary payer.

Self-funded groups who use our administrative services are able to set their own time frames for filing claims for their members. The self-funded plan provisions shown in the table below supersede any provider contract filing limits.

Non-Participating Providers

Claims must be received within the following time frames after the date-of-service:

- **Commercial:** 18 months, except for members affiliated with self-funded groups that have set their own limits as shown in the table below.

Self-Funded Group Timely Filing Limits		
Group	Limit	Effective
BCTGM Local 53	180 days	Jan. 1, 2020

- **Medicaid and Child Health Plus (CHPlus):** 15 months.
- **Medicare:** 365 days.

Behavioral Health and Dental Providers

Behavioral health providers should reference the Carelon Behavioral Health Provider Handbook and dental providers should reference the Office Manager's Handbook section 3.1 for applicable timely filing limits.

The best way to check claims status is through the provider portal.

Remember, the Claims Corner section of our website is available 24/7 to provide guidance, resources, and answers to most claims-related questions.

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Reminders

Correct CPT Code Use

- Check the coding crosswalk to confirm that the codes you are submitting are compatible with each other before billing.
- Confirm that the age of the member matches the diagnosis code billed on the claim.
- When billing a bilateral CPT code, verify that the code is inherently bilateral, meaning providers need not add any additional modifier. For codes where the LT/RT modifier is required, make certain to add the modifier in two different lines as two separate units or, as per the CMS guidelines, bill the CPT with the 50 modifier.

Provide Complete Medical Records and Correct Claim Form Information

- For coding denials, send the appropriate medical records for the claim to be reviewed. To submit records, look up the claim in our provider portal, click the **Ask a Question** button, enter message, and attach records.
- When indicated/appropriate, provide complete medical records to ensure the claim is not denied for additional information needed.
- Verify that the correct service location address is displayed in box number 32 on the claim form.

No Split Billing

- Wait to bill all services rendered on the same day together so amounts owed and member's cost-share can be correctly calculated.

See our **Reimbursement Policies** at bit.ly/our-rp for more guidance on submitting clean, correctly coded claims.