Claims Submission Time Frames

Dates of Service (DOS) starting July 1, 2008

Timely Filing Requirements:

All claims must be received by the plan within six (6) months from the date the service was provided in order to be considered for payment. Claims received after this time frame will be denied for failure to file timely.

Timely Resubmission:

Claims that have been denied due to erroneous or missing information must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month in which the denial occurred, which ever is later. In order to be considered the denied claim must be resubmitted with corrected information via the website or via paper. When resubmitting a denied claim on paper more than six (6) months after the month of service, a copy of the Explanation of Payment (EOP) with the denial must be attached to demonstrate that the original claim was submitted timely. Please include the word "resubmission" and the claim number on the claim form to help us identify that this is a resubmission of an existing claim.

Claim Adjustment:

Providers may resubmit a claim(s) to correct a simple billing error or to request an adjustment if you believe the payment made by the plan is incorrect. In order to be considered for payment claims in this category must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month of payment on the EOP, which is later. Please include the word "resubmission" and the claim number on the claim form to help us identify that this is a resubmission of an existing claim. A Provider Adjustment form must be completed for all resubmission requests along with the supporting documentation. Your claim will be reviewed and a decision rendered based on the information provided.

Provider Claim Appeal:

All appeals of a denied claim must be received in writing and filed within thirty (30) days of the date of denial (date of EOP) in order to be considered. The written correspondence must clearly indicate that you are appealing a denial of a claim. Claim appeals submitted after the thirty (30) day time frame will be denied for failure to request the appeal timely.

COB Timely Filing:

Claims originally filed timely with a third party carrier must be received within 180 days of the date of the primary carrier's EOP, but never more than twelve (12) months from the month of service.

Outlier Claims Consideration:

All requests for outlier appeal consideration must be submitted in writing and received within three (3) months of the date of the initial EOP on which the claim appears. If the request and all required documentation are not received by the plan within three (3) months of the initial EOP payment, the outlier reconsideration request will be denied for failure to request payment reconsideration in a timely manner. Facilities requesting outlier payment consideration must submit the following documents with the request:

- A cover letter indicating the request is for outlier appeal consideration
- The original UB04 (red and white) claim and an itemized bill
- A copy of the EOP on which the original claim appears
- All requests for outlier consideration will process in a timely manner. Notification of the decision will appear on the EOP or a letter if the claim does not qualify for outlier consideration.
- Utilization review notes signed and dated, physician's orders, physician's discharge summary, inhalation therapy notes, and operative notes. Utilization review notes must indicate the severity of illness/intensity of service (SI/IS) that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of your DRG outlier request. Only required documentation should be submitted. If the entire medical record is submitted, the request may be denied. In some cases more information is required to complete the review process. When additional information not identified above is requested, it must be received within thirty (30) days of the date of request. If not received by the due date, the request for outlier payment will be denied. Please ensure that the request is clearly marked Outlier Appeal Consideration Request and mailed to:

  Peach State Health Plan
  P.O. Box 3030
  Farmington, MO 63640-3812

Clean Claims:

Clean claims will be processed within 15 business days of receipt of the clean claim.

Website Requirements:

Peach State maintains a website that is available to members and providers to assist in obtaining information about participating providers, plan policies and submission of claims. The website can be accessed at www.pshp.com and provides the following types of services:

Searchable provider directory with options to search by:

- Provider name
- Specialty
- Location (city, county, zip)
- Allows providers to submit inquiries and receive response from the plan via the website

- Providers may also submit process, edit and resubmit claims electronically via the secure portion of the website.
- Providers may also access their provider remittance advice via the portal within one business day of the plan issuing payment.
- Providers that are not currently registered for the portal may request access by completing a web portal registration form. Forms are available on our website at www.pshp.com. Registration forms should be faxed to Peach State at **1-877-683-3155**.

Provider Appeals/Consolidated Complaints

In accordance with the revisions in the bill, Peach State will allow providers to batch multiple claim appeals that are similar in nature using the revised Provider Adjustment Form. The revised policy will apply only to claims with dates of service that occur after July 1, 2008. The adjustment form must be marked to indicate the nature of the complaint and the number of items attached.

- Providers will have thirty (30) days from the date of the EOP to initiate a written request for an appeal of a denied claim. The written correspondence must clearly indicated that you are appealing a denial of a claim.
- Appeals received after the thirty (30) day time frame will be denied for failure to request the appeal in a timely manner. Appeals should be submitted to:

  Peach State Health Plan
  P. O. Box 3000
  Farmington, MO 63640-3812
- A decision will be rendered within thirty (30) days of receipt of the appeal and you will receive notification of the decision via the EOP notice or written correspondence. If you are still not satisfied with the decision of the committee, you have the option of choosing an Administrative Review or Binding Arbitration. The request for Administrative Review or Binding Arbitration must be submitted within thirty (30) days of receipt of the plan's decision. Request received after this time frame will not be considered.
- If your claim was denied or underpaid, but subsequently overturned on appeal, an adjustment will be made to pay the additional amount owed. In addition to the amount paid, twenty (20%) percent interest will be applied to the claim(s) and calculated starting 15 days after the claims was received. The interest payment will appear on the EOP.

Reimbursement for Emergency Health Care Services

Prior notification/authorization is not required by Peach State to pay emergency health care services. Hospitals that participate in the automated adjudication program will continue to have their claims processed per the guidelines and categories established in their agreements.

Hospitals that are processed according to the non-automated ED claims adjudication process will have their claims processed per the guidelines and categories established in their agreement with Peach State or at the rate established by Georgia FFS Medicaid for medical emergencies (if the facility is a non participating provider), as

applicable. For services that do not meet the definition of an emergency or that are considered non-emergent, additional criteria will be considered. Note: Medical Records will be required in order to evaluate claims for the severity and nature of presenting symptoms; therefore you must submit a request for reconsideration and provide the medical records (see reconsideration process). If you disagree with the decision, both participating and non-participation providers may initiate an appeal.

Listed below is the additional information and criteria that will be utilized during the decision process.

- The age of the patient;
- The time and day of the week the patient presented for services;
- The severity and nature of the presenting symptoms;
- The patients initial and final diagnosis; and
- Other criteria as identified by the DCH, including criteria specific to patients under 18 years of age.
- Additionally Non-Par Providers shall be reimbursed at a rate equal to the rates paid by DCH for Medicaid fee-for service claims.
- In certain situations you may be required to provide the medical records in order to consider all of the items listed above. In those cases, you will receive an EOP from the plan requesting the medical records.

Note: Exclusions are for OB Delivery Services, Inpatient Hospitalizations, and Observation services only.

Newborn Payment Responsibility

Peach State is responsible for payment of services for newborn infants born to Peach State enrolled mothers until the newborn is discharged to a home environment. Listed below is additional information regarding payment responsibility for newborns:

- Inpatient care for newborns born on or after their mothers' effective date will be the responsibility of the mothers' assigned plan for up to 30 days.
- Members that are enrolled with Peach State and are hospitalized in an inpatient facility will remain the responsibility of the plan until they are discharged from the facility, even if they change to a different CMO, or they become eligible for coverage under the FFS or another category of Medicaid eligibility during their inpatient stay. These members will remain the responsibility of their assigned plan for all covered services, even if the start date for eligibility is made retroactive to a date prior to the hospitalization.
- The payment responsibility includes services requiring the newborn to be transported to another healthcare facility for authorized treatment/care and subsequently returned to the original facility.

Newborn Payment Responsibility

Transition of Care Payment Responsibility

- Peach State's transition of care policy includes coverage for up to 30 days for procedures that are already authorized and scheduled to occur after the new plan effective date.
- In the event a newborn is disenrolled from Peach State and re-enrolled into the Georgia Families fee- for-service program or another Medicaid health plan, Peach State will work with the receiving plan to ensure that the newborn's care is coordinated appropriately until the newborn is discharged and placed in an appropriate care setting.

Eligibility Payment Responsibility (72 Hour Eligibility Rule)

Providers will be required to verify member eligibility via the Georgia Medicaid Management Information System web portal, www.mmis.georgia.gov, prior to providing services to Peach State members. Peach State will honor claims in cases where the services are performed within 72 hours of the eligibility verification. Listed below are instructions and procedures that must be followed in order to comply with this policy:

- Eligibility verification must be completed via the Georgia Medicaid Management Information System web portal at www.mmis.georgia.gov
- Providers must print and maintain a valid copy of the eligibility screen shot and provide the information to the plan in the event that a claim appeal is required to process the claim. The screen shot must contain a date/time stamp in order to be considered valid.
- In order to reimburse providers for these services, in most case you will need to initiate an appeal and supply the plan with proof that verification was obtained via the Georgia Medicaid Management Information System web portal within the 72 hour time frame.
- Appeals should be submitted to:

  Peach State Health Plan
  P.O. Box 3000
  Farmington, MO 63640-3812

PLEASE NOTE: This policy only applies if the steps identified above are followed. As a reminder, Medicaid is the payor of last resort; therefore this policy does not supersede CMS policy related to Coordination of Benefits.

Hospital Statistical Reports (HS&R)

Effective July 1, 2008, HS&Rs will be generated by Peach State and made available within thirty (30) days of receipt of a written request from the provider. Hospitals that wish to receive the report must submit the written request to the address and contact listed below:

Peach State Health Plan
VP of Contracting
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
ATTN: HS&R Report Request

The hospital must provide the following information in order to generate the report; Peach State in turn will provide the report in the format prescribed by DCH within thirty (30) days of receipt of the request:

- Hospital Name
- Hospital Tax ID Number
- Hospital fiscal year or period they want the report generated for

Contracting Conditions

Peach State does not require providers to sign exclusive agreements as a condition of contracting with the plan. Additionally, we have no stipulations in our agreements which require providers to participate in multiple product lines. If you have questions or if you need additional clarification regarding this policy, please contact the Provider Solutions Department at 866-874-0633 for assistance. Provider solutions can direct you to a Contracting Manager for assistance.

Critical Access Hospitals (CAHs)

Peach State currently contracts with all Critical Access Hospitals in the regions we serve. In order to comply with the requirements of the bill our Contracting department will be working directly with each hospital and if appropriate, amending the current agreement to reflect rate and reconciliation requirements specified in the new law. A member of the Contracting department will be meeting directly with you to ensure that the following occurs as required by the new law:

- Each hospital is educated about the rate changes and associated reconciliation process
- Where appropriate, amend the contracts to comply with the new reimbursement rates
- Educate hospitals about the notification requirements for the Plan and the Department of Community Health relative to any concerns regarding any potential contract breach issues.

If you have questions in the interim or if you need additional clarification regarding these changes, you may contact the Provider Solutions Department at **1-866-874-0633**. Provider Solutions can direct you to a Contracting Manager for assistance.