Timely Filing Requirements: Scenarios for Overrides and Demonstrating Good Cause

Both professional billers and facilities have 120 days from the date of the service to submit a clean claim to Colorado Community Health Alliance (CCHA) for processing when CCHA is the primary payer. If CCHA is the secondary payer, the time period is 365 days. Claims are defined as clean when they are submitted without any defects, with all information required for processing, and within the timely filing period.

For corrected claims with a date of service prior to July 1, 2022, the time period is 120 days from the date of service for participating providers. For corrected claims with a date of service July 1, 2022, forward, the time period is 365 days from the date of service for participating providers. For corrected claims for non-participating providers, the time period is 365 days, regardless of the date of service. If you need further information on this topic, select the link **How to Submit a Corrected Claim** or go to **CCHAcares.com/providertools** > Behavioral Health Providers > Claims and Billing > How to Submit a Corrected Claim.

We will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, when a provider can:

- Provide a date of claim receipt compliant with applicable timely filing requirements.
- Demonstrate *good cause* exists.

If the claim is submitted:

- **By mail**: The provider must provide an official mailing service return receipt/delivery confirmation; additionally, the provider must provide a copy of the claim log that identifies each claim included in the submission.
- **Electronically**: The provider must provide the clearinghouse-assigned receipt date from the reconciliation reports.

Good cause may be established by the following:

- If the claim reconsideration request includes an explanation for the delay (or other evidence that establishes the reason), we will determine good cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, we will contact the provider for clarification or additional information necessary to make a *good cause* determination.

Good cause may be found when a provider claim filing delay was due to:

- Administrative error — incorrect or incomplete information furnished by official sources to the provider.
- Retroactive enrollment — member subsequently received notification of enrollment effective retroactively to or before the date of service.

- Incorrect information furnished by the member to the provider resulting in an erroneous filing with another health insurance plan or with their state Medicaid plan.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the provider to secure such documentation or evidence.
- Unusual, unavoidable, or other circumstances beyond the service provider's control that demonstrate the provider could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the provider's records unless such destruction or other damage was caused by the provider's willful act of negligence.