



# Timely Filing: What Every Practice Needs to Know

■ Nikki Benedict

**T**imely filing is a critical concept in medical billing that directly impacts claim reimbursement. Despite its importance, the specific requirements and terminology can vary across payer contracts, making it essential for billing teams to understand both the general rules and the payer-specific nuances.

When reviewing a payer contract, timely filing requirements may be outlined under the following sections:

- Submission/Adjudication of Claims
- Payment
- Time to File Claims

Providers can find Medicare and Medicaid timely filing requirements by consulting Centers for Medicare & Medicaid Services (CMS) and relevant state Medicaid websites. For example, Texas Medicaid requires claims to be filed within 95 days, and Florida Medicaid requires claims to be filed within 12 months of the date of service. Medicare is the only constant, as policies generally allow up to 12 months from the date of service or date of primary payment.

For most urgent care claims, the timely filing period begins at the time of service. For example, payers such as many of UnitedHealthcare's commercial insurance products have a 90-day filing limit, which means providers must submit claims within 90 days of the patient encounter. The timely filing limit is generally non-negotiable in a payer agreement, so the payer may deny the claim for timely filing even if the claim would otherwise have been reimbursable.

For secondary or tertiary claims, however, the timely filing period often begins on the date of the primary payer's determination, not the original date of service. This distinction is important in cases where delays occur while

waiting for an explanation of benefits or responses from primary insurers, as it can impact filing timelines and prevent denials.

When claims are denied, most payers assign separate deadlines for submitting corrections or appeals. There are some exceptions to this.

- **Payer System Errors:** If a payer experiences internal issues that delay processing, they may allow late submissions.
- **Retroactive Eligibility:** When a patient is approved for coverage after receiving care (eg, backdated Medicaid enrollment), some payers allow the filing deadline to restart from the eligibility confirmation date. However, this often requires manual appeals and supporting documentation.
- **Public Health Emergencies:** During events like the COVID-19 pandemic, many payers temporarily extended filing deadlines to support overwhelmed healthcare systems. This often happens regionally in the case of natural disasters like hurricanes or tornados.

If a claim is submitted after the deadline and no exception applies, it is typically written off as appeal rights are lost. However, if the claim is filed on time and subsequently denied, it may still be eligible for appeal and reconsideration by the payer. In most cases, payers do not allow providers to bill patients for claims denied due to timely filing issues, although this can vary depending on the payer's processing rules and the specific terms outlined in provider contracts.

There are several factors that could hold up filing a claim:

- Incomplete documentation of the medical records or delays in completing the charts
- Missing or incomplete patient demographic or insurance information
- Eligibility or coordination of benefit issues
- Missing prior authorization, workman's compensation claim numbers, or referrals (if required)
- Providers not yet credentialed with payers at the time of service



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## REVENUE CYCLE MANAGEMENT

Claims rejected at the clearinghouse level may never reach the payer, yet the clock for timely filing continues to run. Monitoring these rejections closely and acting swiftly ensures claims are corrected and resubmitted within the deadline. Additionally, clearinghouses provide the submission documentation often required to prove timely filing during appeals.

To ensure claims are submitted within payer-specific timely filing deadlines, healthcare organizations should follow several best practices.

- **Insurance Verification:** Confirm insurance eligibility at the time of service. Ensure the correct payer is selected in the system and that all patient demographic and insurance details are accurate, including plan types like Medicare Advantage or managed Medicaid. Always verify whether the patient has multiple coverage sources to ensure proper coordination of benefits.
- **Timely Documentation:** Delays in charting can directly impact the billing timeline and increase the risk of missing filing deadlines. Work closely with providers to complete documentation and close encounters promptly. This includes signatures. Claims are not billable if the medical record is not signed.
- **Rejection Tracking and Analysis:** Routinely review claim rejections and denials, using them as learning opportunities. Identifying patterns and providing feed-

back helps reduce repeat issues and increases the number of clean claims submitted on the first attempt.

- **Credentialing Awareness:** Make sure providers are credentialed with key payers before seeing patients under those plans. Understanding which contracts are in place helps ensure providers are only scheduled with patients whose insurance can be billed appropriately.
- **Proactive Monitoring:** Leverage claim scrubbing tools, clearinghouse alerts, dashboards, and reports to catch and resolve issues early in the revenue cycle. Ongoing monitoring helps prevent bottlenecks and keeps claims moving forward efficiently.

At Experity, we maintain compliance with timely filing requirements by proactively reviewing contract language and collaborating with clinics to ensure timely documentation and claim submission.

Understanding the nuances of payers' timely filing deadlines, exceptions, and appeal rights are essential for optimizing revenue. While missed deadlines can lead to lost reimbursement, many denials that appear final can be overturned with a strong, well-documented appeal. By identifying common barriers and collaborating with an experienced revenue cycle management organization, providers can mitigate financial risk and improve reimbursement efficiency. ■

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