Mass General Brigham
Health Plan

Timely Filing Best Practices

Timely Filing Claim Submission Guidelines for Original Claims

- Mass General Brigham Health Plan requires the submission of all paper and electronic claims within 90 days of the date of service unless otherwise contractually agreed
- A claim that is filed outside of the timely filing period is not considered a clean claim

Timely Filing Claim Submission Guidelines for Adjusted Claims

- To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim originally denied
- Disputes received beyond 90 days will not be considered
- If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the provider's control, the provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit and any supporting documentation

Appropriate Supporting Documentation to Contest an Untimely Filing Denial

Paper Claims

- A copy of the computerized printout of the Patient Account Ledger indicating the claim was billed to Mass General Brigham Health Plan, with the submission date circled in black or blue ink
- Copy of Explanation of Benefits (EOB) from the primary insurer that shows timely submission (90 days) from the date carrier processed the claim
- Proof of follow-up with the member for lack of insurance information, such as proof that the member or another carrier had been billed, if the Member did not identify him/herself as a Mass General Brigham Health Plan member at the time of service

Electronic (EDI) Claims

- For claims submitted through a clearinghouse: A copy of the transmission report and rejection report showing the claim did not reject at the clearinghouse, and the claim was accepted for processing by Mass General Brigham Health Plan within the time limit
- For claims submitted directly to Mass General Brigham Health Plan: The corresponding report showing the claim did not reject at Mass General Brigham Health Plan and was accepted for processing by Mass General Brigham Health Plan within the time limit
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim to denial by Mass General Brigham Health Plan

Note: The above criteria pertain to Commercial and MGB ACO programs

For more information, reference the Mass General Brigham Health Plan Provider Manuals

- Commercial Provider Manual.pdf (massgeneralbrighamhealthplan.org)
- MGB ACO Provider Manual.pdf (massgeneralbrighamhealthplan.org)