



May 8, 2008

Dear DPCI Provider:

As part of our ongoing commitment to service excellence, we are pleased to inform you of a positive change to Delaware Physicians Care, Inc. (DPCI) timely filing requirements. Effective June 1, 2008, DPCI's timely claim submission requirements for initial claim submissions will change from ninety (90) days to one hundred twenty (120) days from the date of service.

In order to keep your DPCI Provider Manual as up-to-date as possible, enclosed are replacement pages addressing timely claim submission requirements. The chart below provides detail on applicable sections affected by the current update as well as the page numbers you are asked to replace.

Section Number	Replace the Following Pages	Explanation of Updates
Section XIII – Billing Procedures	Pages 62-63	Updated Timely Claim Submission Requirements
Appendix Section XXI	Section 13	Revised Claims Resubmission/Reconsideration Form and DPCI criteria to initiate a review to override timely filing claim denials

These updates and the DPCI Provider Manual are also available on our web site, www.DelawarePhysiciansCare.com. As always, do not hesitate to contact your Provider Relations Representative with questions. Thank you for your continued support and dedication to our members.

Sincerely,

Mike McGarrigle

Mike McGarrigle
Director, Provider Relations

0723 = Circumcision
0724 = Birthing Center
0729 = Other labor room / delivery
0760 = Treatment / Observation room general
0761 = Treatment room
0762 = Observation Room
0769 = Other treatment

Documentation needed:

- UB claim form
- Itemization
- Complete Medical record

Timely Claim Submission Requirements

DPCI requires that claims be submitted within one hundred twenty (120) days from the date of service. Providers have twelve (12) months from the date of service to correct and resubmit claims if the initial submission was within the one hundred twenty (120) day time period. DPCI also requires clean claim submissions. A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the Provider of service or from a third party.

Claims Resubmission / Reconsideration

Providers have twelve (12) months from the date of service to correct and resubmit claims if the initial submission was within the one hundred twenty (120) day time period.

- **Resubmission:** A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information.
- **Reconsideration:** A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors.

A resubmission or reconsideration should be submitted with the Provider Claims Resubmission/Reconsideration Form (included in the Appendix) to the following address:

Delaware Physicians Care, Incorporated
Claims Department
ATTN: Reconsiderations/Resubmissions
PO Box 61145
Phoenix, AZ 85082-1145

Claims Inquiries

DPCI claims staff accepts telephonic and written inquiries from providers concerning claims issues. Please ensure that the following information is included with the inquiry.

- Member's DPCI identification number, date of service, procedure code, Provider's name and claim number (if known).

To check on claims status, please check DPCI's website at www.DelawarePhysiciansCare.com or contact the Claims Department at (866) 543-2167.

Written inquiries should be directed to the claims staff at:

Delaware Physicians Care, Inc. (DPCI)
Attn: Claims Department
PO Box 61145
Phoenix, AZ 85082-1145

Third Party Resources

DPCI is by law, the payor of last resort. Therefore, providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing DPCI, as required in the Participating Health Agreement (contract).

Once the other carrier has been billed and an EOB has been received, the claim may then be submitted to DPCI. A completed copy of the EOB should be attached to the submitted claim. The EOB and claim must be submitted within one hundred twenty (120) days from the date of the EOB, so long as it is within twelve (12) months from the date of service. Claims will be denied if they are submitted without an EOB or if the other insurance carriers' requirements are not met.

If assistance with the billing of the third party payors is required, please contact a DPCI Provider Relations Representative at (800) 287-9860.

To prevent denials for coding mismatches, claims submitted to the primary carrier on a form that differs from DPCI requirements should be clearly marked with COB Form Type Conversion.

Timely Filing Denials - Override Review Criteria

It is the responsibility of the provider to maintain their account receivables records, and we recommend providers perform reviews and follow up of their account receivables on at least a monthly basis to determine outstanding Delaware Physicians Care, Incorporated (DPCI) claims. *DPCI will not be responsible for claims that were not received and the date of service exceeds the timely filing limit of one hundred twenty days (120) from the date of service.*

Recognizing that providers may encounter timely filing claim denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by providers.

DPCI criteria to initiate a review to override timely filing:

Electronic submission

Electronic claim submission (EDI) reports are available from each provider's claims clearinghouse after each EDI submission. These reports detail the claims that were sent to DPCI and received by DPCI. Provider must submit hard copy or electronic copy of the acceptance report from the provider's clearinghouse that indicates the claim was accepted by DPCI within the 120-day timely filing limit to override timely filing denial and pay the claim.

Please confirm that the claim did not appear on your rejection report. If DPCI determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the provider.

Paper submission

Provider must submit a screen print from the provider's billing system or database *with documentation* that shows the claim was generated and submitted to DPCI within the 120-day timely filing limit.

Documentation should include:

The system printout that indicates somewhere on the printout:

- That the claim was submitted to DPCI
- Name and ID number of the DPCI member
- Date of service
- Date the claim was filed to DPCI
- A copy of the original CMS-1500 or UB-04 claim form that shows the original date of submission