Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Requirements for Documentation of Proof of Timely Filing		
Effective Date: **09/28/17**	Committee Approval Obtained: **09/28/17**	Section: **Administration**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup 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. **Documentation of Claim Receipt** The following information will be considered proof the claim was received timely. If the claim is submitted: • By U.S. mail: return receipt requested or by overnight delivery service; the provider must provide a copy of the claim log that identifies each claim included in the submission. • Electronically: The provider must submit the clearinghouse-assigned receipt date from the reconciliation reports. • By fax: The provider must submit proof of facsimile transmission. • By hand delivery: The provider must submit a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery. The claims log maintained by providers must include the following information: • Claimant's name • Claimant's address • Claimant's telephone number • Claimant's federal tax identification number • Addressee's name • Carrier's name • Designated address • Mailing or hand delivery date • Subscriber's name • Subscriber's ID number • Patient's name • Date(s) of service/occurrence, total charge and delivery method **Good Cause** Good cause may be established by the following: • If the claim 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 physician or supplier claim filing delay was due to: • Administrative error (incorrect or incomplete information furnished by official sources to the physician or supplier). • 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 physician or supplier resulting in 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 physician/supplier to secure such documentation or evidence. • Unusual, unavoidable or other circumstances beyond the service provider's control, which demonstrate that the physician or supplier could not reasonably be expected to have been aware of the need to file timely. • Destruction or other damage to the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.
Exemptions	• There are no exemptions to this policy.
History	• Biennial review approved 09/28/17: Policy language updated; Policy template updated • Biennial review approved 11/09/15: Policy language updated • Effective 06/01/14: Exited Ohio • Biennial review approved 11/18/13 and effective 11/18/13: Policy language updated; template updated • Review approved 11/07/11 and effective 11/15/06: Background section/policy template updated • Review approved 09/21/09: Background section/policy template updated • Initial policy approval and effective date: 11/15/06
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Timely Filing
Related Materials	• Acknowledgement of Receipt and Received Date for EDI Submission