Reimbursement Policy

Subject: Claims Timely Filing

Effective Date: **05/04/18**	Committee Approval Obtained: **05/04/18**	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/Medicare. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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	The initial claim must be received and accepted in compliance with federal and/or state mandates regarding claims timely filing requirements (Exhibit A) to be considered for reimbursement. In the absence of such mandates, Amerigroup follows the standard of: • 90 days for participating providers and facilities.

	• 12 months for nonparticipating providers and facilities. Timely filing is determined by subtracting the date of service from the date Amerigroup receives the claim and comparing the number of days to the applicable federal or state mandate. If there is no applicable federal or state mandate, then the number of days is compared to the Amerigroup standard. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. If the member has other health insurance that is primary, then timely filing is counted from the date of the *Explanation of Payment* of the other carrier. Claims filed beyond federal, state-mandated or Amerigroup standard timely filing limits will be denied as outside the timely filing limit. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit. Amerigroup reserves the right to waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.
Exemptions	• There are no exemptions to this policy.
History	• Biennial review approved and effective 05/04/18: Exhibit A updated for Florida o Effective 09/01/19: Exhibit A updated for New Jersey • Review approved 06/05/17: Exhibit A updated • Review approved 04/03/17: Policy template updated • Update due to regulatory directive: Market Timely Filing Requirements Exhibit A update for Washington effective 01/01/17 • Biennial review approved 08/01/16: Policy template updated; Kansas, Maryland, and Texas Exhibit A updated o Effective 08/01/16: Medicare Advantage Exhibit A updated • Update due to regulatory directive: Market Timely Filing Requirements Exhibit A update for Kansas effective with a date of service 01/01/16 and after • Effective 02/29/16: Tennessee Exhibit A updated • Review approved and effective 11/04/15: Policy title updated; corrected claims policy language removed; Florida, Georgia, New Jersey, Tennessee and Texas Exhibit A updated • Review approved 08/24/15: Texas Exhibit A updated

	• Effective 02/03/15: Exhibit A updated; exemptions for Georgia, Tennessee, and Texas removed and added to Exhibit A
	• Effective 01/27/15: Tennessee Exhibit A updated
	• Effective 08/04/14: Tennessee Exhibit A updated
	• Update due to regulatory directive: Market Timely Filing Requirements Exhibit A update for New Jersey effective 07/01/14
	• Biennial review approved 06/09/14: Paper and electronic corrected claims language updated; New Mexico exemption removed; Exhibit A updated
	• Effective 04/14/14: Tennessee exemption and Exhibit A updated
	• Review approved and effective 07/01/13: Exhibit A updated, disclaimer updated
	• Review approved 08/27/12: Exhibit A requirements added for Kansas
	• Review approved and effective 05/11/12: Exhibit A requirements updated for Florida; Washington requirement added
	• Biennial review approved 11/07/11 and effective 06/16/10: Background and policy template updated; Texas and Tennessee exemptions added; Florida, Georgia, Tennessee, and Texas requirements updated in Exhibit A
	• Update due to regulatory directive:
	    o 06/16/10: Added New Mexico exemption; removed South Carolina from Exhibit A; Background section/policy template updated
	• Review approved and effective 09/21/09: Market Timely Filing Requirements exhibit updated for Florida, New Jersey, New Mexico, and Ohio; D.C. removed
	• Review approved and effective 12/15/08: OHI information clarified; timely filing waiver/Georgia corrected claim exemptions added; contracting/appeals process exemptions removed; Market Timely Filing Requirements updated
	• Update due to regulatory directive:
	    o 07/28/08: Updated Market Timely Filing Requirements exhibit for Georgia Families per Chapter 200 of the Medicaid Policy & Procedure Manual
	• Initial approval and effective date: 08/09/06

References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Reimbursement Policy Definitions**
Related Policies	• Corrected Claims

	• Reimbursement for Eligible Billed Charges • Requirements for Documentation of Proof of Timely Filing
Related Materials	• EDI Claims Companion Guide for Professional Services

Exhibit A: Market Timely Filing Requirements

Market	Claims Timely Filing Requirement — Calendar Days	
	Participating	**Nonparticipating**
Florida	180 days	365 days
Georgia	180 days from the first calendar day following the month in which services were rendered	180 days from the first calendar day following the month in which services were rendered
Kansas	180 days	180 days
Maryland	180 days	180 days; 6 months for undisputed claims where member has self-referred
Medicare Advantage	12 months	12 months
New Jersey	180 days	12 months; 30 days from provision of services for EPSDT services
Tennessee	120 days	120 days
Texas	95 days from date of service, date of discharge or receipt of state-assigned ID (TPI — Texas Provider Identifier); 365 days from date of service for nursing facility; 95 days from date of service for nursing facility add-on services	95 days from date of service, date of discharge or receipt of state-assigned ID (TPI — Texas Provider Identifier); 365 days from date of service for nursing facility; 95 days from date of service for nursing facility add-on services; 365 days — out-of-state providers
Washington	365 days	365 days