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Reimbursement Policy
Claims Timely Filing

Policy Number: G-06050
Policy Section: Administration
Last Approval Date: 06/03/2025
Effective Date: 06/03/2025

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.amerigroup.com/georgia-provider/**.

Policy

The health plan will consider reimbursement for the initial claim when received and accepted within the applicable timely filing limit, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

The health plan follows the standard of:

- Six months following the month in which services were rendered for participating providers and facilities
- Six months following the month in which services were rendered for nonparticipating providers and facilities

Timely filing is determined by subtracting the date of service from the date we receive the claim and comparing the resulting 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 health plan standard. If services are rendered on consecutive days, 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 primary health insurance, then timely filing is counted from the date of the Explanation of Payment (EOP) from the other carrier.

Claims filed outside the timely filing limit will not be subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

The health plan reserves the right to waive the timely filing requirements on a temporary basis following documented natural disasters or in accordance with applicable state guidance.

Related Coding
Standard correct coding applies.

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
- Corrected Claims
- Eligible Billed Charges
- Proof of Timely Filing

References and Research Materials
This policy has been developed through consideration of the following:
- CMS
- State contract
- State Medicaid

Policy History
- 06/03/2025 - Review approved and effective: no changes
- 12/27/2022 - Review approved: policy template updated
- 08/07/2020 - Review approved: updated Georgia from 180 days to six months; Exhibit A removed
- 05/04/2018 - Review approved and effective
- 06/05/2017 - Review approved: Exhibit A updated
- 04/03/2017 - Review approved: policy template updated
- 08/01/2016 - Review approved: policy template updated
- 11/04/2015 - Review approved: policy title updated; corrected claims policy language removed; Georgia Exhibit A updated
- 08/24/2015 - Review approved policy updated
- 02/03/2015 - Exhibit A updated
- 06/09/2014 - Review approved: paper and electronic corrected claims language updated
- 04/14/2014 - Exhibit A updated
- 07/01/2013 - Review approved: Exhibit A updated; disclaimer updated
- 05/11/2012 - Review approved
- 11/07/2011 - Review approved and effective 06/16/2010: Background and policy template updated; Georgia requirements updated in Exhibit A
- 12/15/2008 - Review approved and effective: OHI information clarified; timely filing waiver/Georgia corrected claim exemptions added; contracting/appeals process exemptions removed; Market Timely Filing Requirements updated
- 07/28/2008 - Update due to regulatory directive: updated Market Timely Filing Requirements exhibit for Georgia Families per Chapter 200 of the Medicaid Policy & Procedure Manual
- 08/09/2006 - Initial approval and effective

Disclaimer
These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The

determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.