Reimbursement Policy	
Subject: **Proof of Timely Filing**	
Policy Number: **G-06133**	Policy Section: **Administration**
Last Approval Date: **11/19/2021**	Effective Date: **11/19/2021**

**** 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/NJ**. ****

Disclaimer

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 Community Care 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 codes 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 our provider website.

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 mail**: The provider must provide official mailing service return receipt/delivery confirmation. Additionally, the provider must provide a copy of the claim log that identifies each claim included in the submission.
- **Electronically**: The provider must provide the clearinghouse assigned receipt date from the reconciliation reports.

The following information **will not be considered** proof the claim was received timely. If the claim is submitted:

- **By fax**: Facsimile transmission
- **By hand delivery**: A claim log that identifies each claim included in the delivery and a copy of the signed receipt.

The mailed claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing
- Subscriber name
- Subscriber ID number
- Member’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 which establishes the reason), Amerigroup will determine good cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, Amerigroup will contact the provider for clarification or additional information necessary to make a Good Cause determination.

Good Cause may be found when a provider claim filing delay was due to:

- Administrative error — incorrect or incomplete information furnished by official sources to the provider.

- 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 provider 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, that demonstrate the provider could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the provider's records unless such destruction or other damage was caused by the provider's willful act of negligence.

Related Coding

Standard correct coding applies.

Policy History

11/19/2021	Biennial review approved and effective: Policy title updated; Policy language updated; the following information will not be considered proof the claim was received timely. If the claim is submitted: fax and hand delivery language. Added the word "mailed" for claim log.
05/24/2019	Biennial review approved and effective: United States mail return receipt language updated; word physician replaced with provider
09/28/2017	Biennial review approved and effective: Retroactive enrollment language added
11/09/2015	Biennial review approved: First class language removed; Background section/policy template updated
11/18/2013	Biennial review approved and effective: good cause language expounded
11/07/2011	Biennial review approved: Background section/policy template updated
09/21/2009	Biennial review approved: Background section/policy template updated
11/15/2006	Initial policy approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contract

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Acknowledgement of Receipt and Received Date for EDI Submission
Claims Timely Filing
Corrected Claims
Eligible Billed Charges