Reimbursement Policy	
Subject: **Claims Timely Filing**	
Policy Number: **G-06050**	Policy Section: **Administration**
Last Approval Date: **12/27/2022**	Effective Date: **12/27/2022**

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

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 STAR+PLUS MMP (Medicare-Medicaid Plan) benefits. 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 STAR+PLUS MMP may:

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

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR+PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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 STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP will consider reimbursement for the initial claim, when received and accepted within timely filing requirements, in compliance with federal, and/or state mandates.

Amerigroup STAR+PLUS MMP follows the standard of 12 months for participating and nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service (DOS) from the date Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP 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 STAR+PLUS MMP 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 STAR+PLUS MMP reserves the right to waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.

Related Coding

Standard correct coding applies

Exemptions

Texas Medicaid	Amerigroup Texas, Inc., and Amerigroup Insurance Company allows timely filing of 365 days for nonparticipating out of state providers. Participating and nonparticipating in state providers are allowed timely fling of: • 95 days from DOS, date of discharge or receipt of Texas Medicaid Enrollment; 365 days from DOS for Nursing Facility; 95 days from DOS for Nursing Facility add-on services for participating providers and facilities • 95 days from DOS, date of discharge or receipt of Texas Medicaid Enrollment; 365 days from DOS for Nursing Facility; 95 days from DOS for Nursing Facility add-on services for non- participating providers and facilities

	• 365 days – for out of state providers

Policy History

12/27/2022	Review approved; policy template updated; Texas exemption updated
08/07/2020	Review approved
05/04/2018	Review approved: policy template updated; Texas exemption updated
04/03/2017	Initial policy approved and effective 10/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contracts

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Corrected Claims
- Eligible Billed Charges
- Proof of Timely Filing
- EDI Claims companion Guide for Professional Services