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

**** The most current version of our 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.anthem.com/kentucky-provider/claims/reimbursement-policies**. ****

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Medicaid (Anthem) if the service is covered by a member's 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, Anthem may:

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

Anthem 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Anthem strives to minimize these variations.

Anthem 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.

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Anthem Kentucky Managed Care Plan, Inc., independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
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Policy

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

Anthem follows the standard of:

- 365 days for participating providers and facilities.
- 365 days for nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service from the date Anthem 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 Anthem 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 Anthem 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.

We reserve 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

Policy History

12/27/2022	Review approved and effective: updated market timely filing requirement for participating language from 180 to 365 days and nonparticipating from 12 months to 365 days; policy template updated
08/07/2020	Review approved
05/04/2018	Review approved: market timely filing limit updated; timely filing waiving language added
08/01/2016	Review approved: policy template updated
11/04/2015	Review approved: policy title updated; corrected claims policy language removed
08/24/2015	Review approved: policy template updated
06/09/2014	Review approved: paper and electronic corrected claims language updated
01/01/2014	Initial approval and effective

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