Nevada | Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

Reimbursement Policy
Claims Timely Filing

Policy Number: **G-06050**
Policy Section: **Administration**
Last Approval Date: **6/3/2025**
Effective Date: **6/3/2025**

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://www.anthem.com/nv/provider**.

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.

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- 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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.

Policy

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

The health plan follows the standard of:

- 180 days for participating care providers and facilities
- 180 days (365 days for out-of-state providers) for nonparticipating care providers and facilities

Timely filing is determined by subtracting the date of service from the date we receive 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 company 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 (EOP) of 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 temporarily waive timely filing requirements following documented natural disasters or under applicable state guidance.

Related Coding

Standard correct coding applies.

Policy History

- **06/03/2025** - Review approved and effective: no changes
- **12/27/2022** - Review approved: policy template updated
- **08/07/2020** - Review approved
- **05/04/2018** - Review approved: policy template updated
- **02/01/2018** - Policy template updated
- **06/05/2017** - Review approved 06/05/2017 and effective 07/01/2017: timely filing limit 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
- **08/24/2015** - Review approved: policy template updated
- **06/09/2014** - Review approved: paper and electronic corrected claims language updated
- **07/01/2013** - Review approved: policy template updated; Disclaimer updated
- **08/27/2012** - Review approved: policy template updated
- **05/11/2012** - Review approved: policy template updated
- **11/07/2011** - Review approved 11/07/2011 and effective 06/16/2010: timely filing limit updated; background and policy template updated
- **09/21/2009** - Review approved: policy template updated
- **02/01/2009** - Initial approved and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Corrected Claims
- Eligible Billed Charges
- Proof of Timely Filing