Tennessee | Medicaid

Reimbursement Policy
Proof of Timely Filing

Policy Number: **G-06133**
Policy Section: **Administration**
Last Approval Date: **10/23/2025**
Effective Date: **10/23/2025**

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.wellpoint.com/tn**.

Policy

The health plan will reconsider reimbursement of a claim that is not accepted due to failure to meet timely filing requirements, unless care provider, state, federal, or CMS contracts and/or requirements indicate otherwise, when a care 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 that the claim was received within the time period outlined in the Claims Timely Filing policy. 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 that the claim was received timely. If the claim is submitted:

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We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 833-731-2154. Information about the civil rights laws can be found at tn.gov/tenncare/members-applicants/civil-rights-compliance.html.
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- 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 that establishes the reason), the health plan will determine Good Cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, the health plan 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, Original Medicare, or State Medicaid plan
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties, despite reasonable efforts by the provider 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 unintentional oversight

Related Coding

Standard correct coding applies.

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Claims Timely Filing
- Corrected Claims
- Eligible Billed Charges

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Policy History

- **10/23/2025 -** Review approved and effective: no changes
- **09/27/2023 -** Review approved and effective: no changes
- **11/19/2021 -** 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 -** Review approved: United States mail return receipt language updated; word physician replaced with provider
- **09/28/2017 -** Review approved: retroactive enrollment language added
- **11/09/2015 -** Review approved: First class language removed; Background section/policy template updated
- **11/18/2013 -** Review approved: Good Cause language expanded
- **11/07/2011 -** Review approved: Background section/policy template updated
- **09/21/2009 -** Review approved: Background section/policy template updated
- **11/15/2006 -** 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.

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