Wellpoint

Washington | Medicaid

Reimbursement Policy
Claims Timely Filing

Policy Number: **G-06050**
Policy Section: **Administration**
Last Approval Date: **06/03/2025**
Effective Date: **06/03/2025**

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/wa.

Policy

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

- 12 months for participating providers and facilities
- 12 months for nonparticipating providers and facilities

Timely filing is determined by subtracting the date of service from the date we receive the claim and comparing the resulting 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 health plan standard. If services are rendered on consecutive days, 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.

Coverage provided by Wellpoint Washington, Inc.
Wellpoint Washington, Inc. profoundly acknowledges and respects the inherent sovereignty of the federally recognized Tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the Tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the Tribes, a bond reiterated by the Centennial Accord and established by RCW 43.376. We heartily commit to enhancing our coordination, collaboration, and recognition of the deeply rooted traditions and values of the Tribal communities.
WA-WP-CD-RP-004170-26-GRP876 | April 2026

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 waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.

Related Coding

Standard correct coding applies.

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

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

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Policy History

- **06/03/2025 -** Review approved and effective: updated timely filing requirement from 365 days to 12 months for participating and nonparticipating providers
- **12/27/2022 -** Review approved and effective: policy template updated; minor administrative changes
- **08/07/2020 -** Review approved: Exhibit A removed
- **08/16/2019 -** Review approved: policy template updated
- **07/03/2019 -** Review approved
- **05/04/2018 -** Review approved
- **06/05/2017 -** Review approved: Exhibit A updated
- **04/03/2017 -** Review approved: policy template updated
- **01/01/2017 -** Updated due to regulatory directive: Market Timely Filing Requirements Exhibit A 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
- **06/09/2014 -** Review approved: paper and electronic corrected claims language updated; Exhibit A updated
- **07/01/2013 -** Review approved: Exhibit A updated; disclaimer updated
- **05/11/2012 -** Review approved and effective: Exhibit A requirements added
- **11/07/2011 -** Review approved **11/07/2011** and effective 06/16/2010: Background and policy template updated
- **12/15/2008 -** Review approved and effective: OHI information clarified; contracting/appeals process exemptions removed; Market Timely Filing Requirements updated
- **08/09/2006 -** 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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