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://provider.wellpoint.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Wellpoint Medicare Advantage covered the service for the 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 Current Procedure 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, Wellpoint Medicare Advantage 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Wellpoint Medicare Advantage strives 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

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

Wellpoint Medicare Advantage follows the standard of:

- 90 days 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 Wellpoint Medicare Advantage receives the claim and comparing the number of days to the applicable federal mandate. If there is no applicable federal mandate, then the number of days is compared to the Wellpoint Medicare Advantage 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 (OHI) that is primary, then timely filing is counted from the date of the *Explanation of Payment (EOP)* of the other carrier.

Claims filed beyond federal, or Wellpoint Medicare Advantage 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.

Wellpoint Medicare Advantage 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

Policy History	
12/27/2022	Review approved: policy template updated
08/07/2020	Review approved
08/16/2019	Review approved and effective 07/01/2020: timely filing for participating providers updated
05/04/2018	Review approved: policy template updated
08/01/2016	Review approved: timely filing requirement clarified
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 removed
11/07/2011	Review approved: policy template updated
12/15/2008	Review approved: OHI information clarified; timely filing waiver exemptions added; contracting/appeals process exemptions removed
08/09/2006	Initial policy approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Corrected Claims
Eligible Billed Charges
Proof of Timely Filing