	Reimbursement Policy	
Subject: Claims Timely Filing		
Effective Date: **10/01/17**	Committee Approval Obtained: **04/03/17**	Section: **Administration**
*****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.amerigroup.com/TX.*****		

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) if the service is covered under the Amerigroup STAR+PLUS MMP 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, Amerigroup STAR+PLUS MMP may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR-PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP 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 this site.

Policy	The initial claim must be received and in compliance with federal and/or state mandates regarding claims timely filing requirements to be considered for reimbursement. Amerigroup STAR+PLUS MMP follows the standard of 12 months for participating and nonparticipating providers and facilities.

	Timely filing is determined by subtracting the date of service (DOS) from the date Amerigroup STAR+PLUS MMP 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 Amerigroup STAR+PLUS MMP 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 Amerigroup STAR+PLUS MMP 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. Amerigroup STAR+PLUS MMP reserves the right to waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.
Exemption	• Amerigroup Texas, Inc. and Amerigroup Insurance Company allow additional timely filing of 365 days for nonparticipating out-of-state providers. Participating and nonparticipating providers are allowed additional timely filing of: o 95 days from DOS, date of discharge or receipt of Texas Provider Identifier. o 365 days from DOS for nursing facilities.
History	• Initial review approved **04/03/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS policies • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Reimbursement for Eligible Billed Charges • Requirements for Documentation of Proof of Timely Filing
Related Materials	• EDI Claims Companion Guide for Professional Services