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TEXAS Health and Human Services

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

	Reimbursement Policy

Subject: Requirements for Documentation of Proof of Timely Filing

Effective Date: **09/28/17**	Committee Approval Obtained: **09/28/17**	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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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	Amerigroup STAR+PLUS MMP will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements unless provider, state, federal or CMS contracts and/or requirements indicate otherwise when a 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 timely. If the claim is submitted: • By U.S. mail: return receipt requested or by overnight delivery service; 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 • By fax: the provider must provide proof of facsimile transmission • By hand delivery: the provider must provide a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery The 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 or hand delivery • Subscriber name • Subscriber ID number • Patient 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), Amerigroup STAR+PLUS MMP will determine good cause based primarily on that statement or evidence. • If the evidence leads to doubt about the validity of the statement, Amerigroup STAR+PLUS MMP will contact the provider for clarification or additional information necessary to make a good cause determination. Good cause may be found when a physician or supplier claim filing delay was due to: • Administrative error (incorrect or incomplete information furnished by official sources to the physician or supplier).

	• 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 physician or supplier resulting in erroneous filing with another Health Insurance plan or with the state. • Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence. • Unusual, unavoidable or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not reasonably be expected to have been aware of the need to file timely. • Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence. • Serious illness, which prevented the party from contacting the contractor in person; in writing; or through a friend, relative or other person. • A death or serious illness in his or her immediate family. • A request was sent to a government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired. • Circumstances beyond the beneficiary's control including mental or physical impairment (e.g., disability, extended illness) or significant communication difficulties. Note: Failure of a billing company or other consultant (that the provider, physician or other supplier has retained) to timely submit appeals or other information is not grounds for finding good cause for late filing.
History	• Biennial review approved and effective **09/28/17**: Policy language updated; Policy template updated • 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	• Claim Timely Filing
Related Materials	• Acknowledgement of Receipt and Received Date for EDI Submission