	Reimbursement Policy	
Subject: Claims Timely Filing		
Effective Date: **05/04/18**	Committee Approval Obtained: **08/07/20**	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 **www.anthem.com/inmedicaiddoc**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield (Anthem) if the service is covered by Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. 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, Anthem may:

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

Anthem reimbursement policies 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem 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 accepted in compliance with federal and/or state mandates regarding claims timely filing requirements to be considered for reimbursement. Anthem follows the standard of: • 90 days for participating providers and facilities. • 180 days for nonparticipating providers and facilities. Timely filing is determined by subtracting the date of service from the date Anthem 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 company 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 company, 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. Anthem reserves the right to waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.
History	• Biennial review approved **08/07/20** • Update due to regulatory directive effective **01/01/20**: Prior to 01/01/19: 12 months On or after 01/01/19: 180 days • Biennial review approved and effective **05/04/18**: Policy template updated • Biennial review approved **08/01/16**: Policy template updated • Review approved **11/04/15**: Policy title updated; corrected claims policy language removed • Review approved **08/24/15**: Timely filing limit updated • Initial policy approval effective **02/01/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Corrected Claims • Reimbursement for Eligible Billed Charges • Requirements for Documentation of Proof of Timely Filing
Related Materials	• EDI Claims Companion Guide for Professional Services