	Reimbursement Policy	
Subject: Claims Timely Filing		
Effective Date: **07/01/20**	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 **https://providers.healthybluela.com**.*****

These 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 Healthy Blue Dual Advantage (HMO D-SNP) member's 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue Dual Advantage may:

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

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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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

Healthy Blue Dual Advantage reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy	To be considered for reimbursement, an initial claim must be received and accepted in compliance with Healthy Blue Dual Advantage claims timely filing guidelines outlined below unless otherwise stipulated by contract. Healthy Blue Dual 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 Healthy Blue Dual Advantage receives the claim and comparing the number of days to the Healthy Blue Dual 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 that is primary, then timely filing is counted from the date of the EOP of the other carrier. Claims filed beyond federal or Healthy Blue Dual 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. Healthy Blue Dual Advantage 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** • Review approved **01/01/20** and effective **07/01/20**: Timely filing for participating providers updated • Initial policy approval effective **01/01/20**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract
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