Reimbursement Policy	
Subject: **Claims Timely Filing**	
Policy Number: **G-06050**	Policy Section: **Administration**
Last Approval Date: **12/27/2022**	Effective Date: **12/27/2022**

**** Visit our provider website for the most current version of our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.healthybluela.com**. ****

Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana 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. 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, Healthy Blue may:

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

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles.

Healthy Blue 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 our provider website.

Policy

Healthy Blue will consider reimbursement for the initial claim, when received and accepted within timely filing requirements, in compliance with federal, and/or state mandates. Healthy Blue follows the standard of 365 days for participating and nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service from the date we receive 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

LAHB-CD-RP-017215-22-CPN16502 February 2023

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 (EOP)* 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.

Healthy Blue 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: minor language updates: policy template updated
08/07/2020	Review approved
05/04/2018	Review approved: timely filing limit updated
09/07/2017	Policy template updated
06/05/2017	Review approved: policy template updated
04/03/2017	Review approved: policy template updated
08/01/2016	Review approved; timely filing limit updated: policy template updated
11/04/2015	Review approved: policy title updated: corrected claims policy language updated: policy template updated
08/01/2015	Market timely filing requirements updated due to regulatory directive
02/01/2015	Market timely filing requirements updated due to regulatory directive
06/09/2014	Review approved: paper and electronic corrected claims language updated
07/01/2013	Review approved; policy template updated
08/27/2012	Review approved: policy template updated
05/11/2012	Review approved: timely filing limit updated
11/07/2011	Review approved and effective 06/16/2010: policy template updated
09/21/2009	Review approved: policy template updated
12/15/2008	Review approved: policy language updated
08/09/2006	Initial policy approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contract

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Corrected Claims
Eligible Billed Charges

Proof of Timely Filing