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://providerpublic.mybcbswny.com**.****

Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) if the service is covered by a member's Highmark BCBSWNY 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 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, Highmark BCBSWNY may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Highmark BCBSWNY 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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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, Highmark BCBSWNY strives to minimize these variations.

Highmark BCBSWNY 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.

Amerigroup Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield of Western New York's managed Medicaid. Amerigroup Partnership Plan, LLC brinda servicios administrativos para Medicaid administrado de Highmark Blue Cross Blue Shield of Western New York.
Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Highmark Blue Cross Blue Shield of Western New York es un nombre comercial de Highmark Western y Northeastern New York Inc., un licenciatario independiente de Blue Cross Blue Shield Association.
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Policy

Highmark BCBSWNY will consider reimbursement for the initial claim, when received and accepted within timely filing requirements, in compliance with federal, and/or state mandates.

Highmark BCBSWNY follows the standard of:

- 120 days for participating providers and facilities.
- 15 months for nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service from the date Highmark BCBSWNY 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, the number of days is compared with the Highmark BCBSWNY 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, timely filing is counted from the date of the explanation of payment of the other carrier.

Claims filed beyond federal, state-mandated, or Highmark BCBSWNY 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.

Highmark BCBSWNY reserves the right to waive timely filing requirements on a temporary basis after documented natural disasters or under applicable state guidance.

Related Coding

Standard correct coding applies

Policy History

12/27/2022	Review approved: policy template updated
08/07/2020	Review approved
05/04/2018	Review approved: policy template updated
04/03/2017	Review approved: policy template updated
08/01/2016	Initial policy approved and effective 01/01/2017

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