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.simplyhealthcareplans.com. ****

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Simply Healthcare Plans, Inc. (Simply) Medicare Advantage if the service is covered by a member's 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 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, Simply Medicare Advantage may:

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

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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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

Simply Medicare Advantage 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.

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Policy

Simply Medicare Advantage will consider reimbursement for the initial claims, when received and accepted within the timely filing requirements, in compliance with federal and/or state mandates.

Simply Medicare 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 Simply Medicare Advantage receives the claim and comparing the number of days to the applicable federal mandate. If there is no applicable federal mandate, then the number of days is compared to the Simply Medicare 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 (OHI) 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, or Simply Medicare 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.

Simply Medicare Advantage 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	Biennial review approved: policy template updated
01/01/2021	Initial policy approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Corrected Claims
Eligible Billed Charges
Proof of Timely Filing
EDI Claims companion Guide for Professional Services