	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 websites. If you are using a printed version of this policy, please verify the information by going to **https://provider.simplyhealthcareplans.com/florida-provider** or **https://provider.clearhealthalliance.com/florida-provider**. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) 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 both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply and CHA may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Simply and CHA reserve 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

<table>
<tr><td></td><td>requirements to be considered for reimbursement. Simply follows the standard of:
• 180 days for participating providers and facilities.
• 365 days for nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service from the date Simply 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 Simply 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 Simply 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 reserves the right to waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.</td></tr>
<tr><td>History</td><td>• Biennial review approved 08/07/20
• Biennial review approved and effective 05/04/18: Timely filing limit updated
• Policy template updated 12/01/18
• Review approved 06/05/17: Policy template updated
• Review approved 04/03/17: Policy template updated
• Biennial review approved 08/01/16: Policy template updated;
• Review approved and effective 11/04/15: Policy title updated; corrected claims language removed
• Biennial review approved 06/09/14: Paper and electronic corrected claims language updated
• Review approved and effective 07/01/13: Disclaimer updated
• Review approved and effective 05/11/12: Policy language updated
• Biennial review approved 11/07/11 and effective 06/16/10: Timely filing limit language and template updated
• Review approved and effective 09/21/09: Policy template updated
• Review approved and effective 12/15/08: OHI information clarified; Timely filing waiver language added; Timely Filing Requirements updated
• Initial policy approval effective 08/09/06</td></tr>
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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