FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

CLAIMS	ASPIRE HEALTH PLAN	**Effective Date** 01/01/18	
		Policy # AHP ASO - CL015	
	Timely Filing of Claims and Provider Dispute Resolution Requests	**Review Date** 5/9/2023	**Applicable to:** ☐ Medicare Advantage ☐ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Elisabeth Fagan, Director of Health Plan Operations	

1.0 PURPOSE

1.1 To outline the process for timely filing of claims and Provider Dispute Resolution (PDR) requests.

2.0 POLICY

2.1 Not to impose a deadline for the receipt of a claim or provider dispute except as is consistent with the California Health and Safety code.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual.

4.0 PROCEDURE

4.1 Unless the written contract states otherwise, all contracted provider claims must be submitted within 180 days of the date of service. All electronic claims will be acknowledged within 2 working days and all paper claims will be acknowledged within 15 working days.

4.2 All non-contracted provider claims must be submitted within 180 days of the date of service. All electronic claims will be acknowledged within 2 working days and all paper claims will be acknowledged within 15 working days.

4.3 The time frame for secondary payer (Coordination of Benefits) claims submission begins on the date the provider receives payment or denial notice from the primary carrier.

4.3 The received date is the date used to determine if the claim is received within the timely filing limits. This date is also used to determine timely processing of the claim.

4.4 Aspire Health Plan will not impose a deadline for the receipt of a commercial provider dispute of a claim or billing that is less than 365 days from the date of last action on the claim, i.e., 365 days from the date the claim was paid or denied or processed in any manner.

4.5 Aspire Health Plan will accept all claims with proof of timely filing attached. Aspire Health Plan may also make one time exceptions as a Goodwill Payment.

4.6 Aspire Health Plan makes claims acknowledgement available in two ways**:**

4.6.1 The provider can call Customer Service to verify the claim has been received.

4.6.2 Providers that are registered for the provider portal are given access to their claims based on TAX ID. Both providers and billers associated with the provider are allowed secured access to the provider's claims. Both the received date and current status of the claim can be verified within the provider portal.

4.7 Provider disputes must be submitted within 365 days of the last action of the claim. Last action may be any of the following:

- Payment of claim
- Denial of claim
- Contesting of claim
- Any written correspondence related to the claim or authorization for the claim

5.0 TRAINING

5.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

6.0 REVIEW PERIOD

6.1 Annually.

7.0 REGULATORY REQUIREMENTS AND REFERENCES

California Health and Safety Code Sections 1371, 1371.35, 1371.36, 1371.37, 1371.38, and 1371.39

California Code of Regulations (CCR) Title 28 Rule 1300.71

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to

disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.