| SHARP HEALTH PLAN POLICY AND PROCEDURE | |
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| SHARP HEALTH PLAN<br><br>**Title:**<br>**Claims Submission Policy** | **Product Line** (check all that apply)**:**<br>☒ Group HMO<br>☒ Individual HMO<br>☐ PPO<br>☒ POS<br>☐ N/A |
| **Division(s): Administration, Finance and Operations** | |
| **Department(s): Claims Research, Customer Care, Network Development, Provider Contracts and Regulatory Affairs** | |
| **Owner (Title): Manager Claims Administration** | |
| **Relevant Regulatory/Accrediting Agencies/Citations (specify):**<br>☐ CMS: _____<br>☒ DMHC: Title 28, California Code of Regulations, Section 1300.71 (AB 1455)<br>☐ NCQA-HP: _____<br>☐ NCQA-WHP: _____<br>☐ OTHER: _____ | |
| **Approved by:** (Signature of VP, Compliance Officer, or CEO)<br>Signature on File | **Approval date:**<br>12/06/12 |

**I. PURPOSE:** This Policy and Procedure establishes Sharp Health Plan's (Plan) guidelines for the submission, acknowledgement and payment of claims.

**II. POLICY:**

**A.** It is the policy of Sharp Health Plan (Plan), as required by regulations outlined in Title 28, California Code of Regulations (CCR), Section 1300.71 (AB1455), to allow **contracted providers to submit claims according to the agreement terms or no less than 90 days from the date of service**.

**B.** It is the policy of Sharp Health Plan (Plan) to allow non-contracted providers to submit a claim up to 180 days after the date of service.

**C.** It is the policy of Sharp Health Plan (Plan) to deny claims submitted outside of these time frames as untimely**.**

**III. DEFINITIONS:**

A. Date of Receipt: The working day when a claim, by physical or electronic means, is first delivered to Sharp Health Plan.

B. Date of Service: For Outpatient and Emergency Services, the date upon which the Provider delivered separately billable health care services. For Inpatient Services, the date upon which the enrollee was discharged from the inpatient

facility. For Inpatient extended lengths of stay Sharp Health Plan will accept separately billable claims for inpatient services on a bi-weekly basis.

C. Provider: Physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, durable medical equipment supplies and other licensed health care entities or professionals which or who provide Covered Benefits to Members. A Provider of health care services may or may not be contracted with Sharp Health Plan.

D. Reasonably Relevant Information: The minimum amount of itemized, accurate and material information generated by or in the possession of the Provider related to the billed services that enables a claims adjudicator to determine the nature, cost, and extent of Sharp Health Plan's liability.

## IV. PROCEDURE:

A. The Plan identifies and acknowledges the receipt of each claim whether or not it is complete, and discloses the recorded Date of Receipt in the same manner that the claim was submitted.

1. In the case of electronic claims submission, acknowledgement is provided within two (2) working days of the Date of Receipt.

2. In the case of a paper claim, identification and acknowledgement is provided within fifteen (15) working days of the Date of Receipt.

    a) In the event that claims have multiple date stamps, the Date of Receipt used shall be the date the claim first reaches Sharp Health Plan Claims Processing.

        i) The received date used for misdirected claims received by Sharp Health Plan Claims will be the date the claim was first received at Sharp Health Plan Claims Processing.

3. In order to process each claim efficiently, all claims submitted to the Plan must contain all Reasonably Relevant Information necessary to determine payer liability.

    a) In the event that the claim does not contain all Reasonably Relevant Information, the Plan submits a clear and accurate written request for additional information required from the Provider.

    b) When the Plan has determined a claim meets the criteria necessary to determine payer liability, the Plan will reimburse the Provider no later than forty-five (45) business days for HMO claims and thirty (30) business days after the Date of Receipt of the complete claim.

        i) In the event that claims are not reimbursed within forty-five business (45) days for HMO claims and thirty (30) business days for POS claims, interest and penalties will be paid to

the provider in accordance with Title 28, CCR, Section 1300.71.

ii) The calculation of interest and penalties will begin after forty-five business (45) days for HMO claims and thirty (30) business days for POS claims after the receipt of a valid claim.

c) If the claim is contested or denied, written notice will be sent to the Provider within forty five (45) business days for HMO claims and thirty (30) business days for POS claims after the Date of Receipt by the Plan.

B. The Plan completes regular claims audits to ensure compliance with Title 28, CCR, Section 1300.71 (AB1455). These audits are conducted in accordance with the Plan's Internal Claims Audit Policy and Procedure.

## V. ATTACHMENTS:

A. Policy and Procedure: Sharp Health Plan Internal Claims Audit Policy

**VI. REFERENCES:** Title 28, California Code of Regulations, Section 1300.71 (AB 1455)

**VII. TAGS:** Claims, Acknowledgement, Claims Processing, Payment, AB 1455

## VIII. REVISION HISTORY:

| Date | Modification (Reviewed and/or Revised) |
|---|---|
| 11/1/2017 | Reviewed and Revised Document |
| 12/31/2015 | Reviewed Document |
| 12/31/2014 | Reviewed Document |
| 10/18/13 | Revised Document |
| 11/12/2012 | Revised Document |
| 12/23/2011 | Reviewed Document |
| 11/01/2010 | Revised Document |
| 03/01/2010 | Revised Document |
| 08/27/2009 | Revised Document |
| 01/02/2007 | Revised Document |
| 12/01/2003 | Revised Document |

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| 09/01/2003 | Original Document |