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## Timely Submission Requirements for Submitting Claims to Alameda Alliance for Health

Effective 10/1/07

### FILING LIMITS FOR CLAIMS TIMELINES

Minimum filing limits for claims are established by the California Code of Regulations (CCR), Title 28, Section 1300.71. Those minimum filing timelines are:

**Contracted providers** may not have a filing limit of less than 90 days from the date of service imposed for claims submission.

**Non-contracted providers** may not have a filing limit of less than 180 days imposed for claims submission after the date of service, except as required by any state or federal law or regulation.

The Alliance will allow additional filing time for claims submissions in the following scenarios:

- Claims involving coordination of benefits – the filing limit will be extended 90 days from the date of the primary carrier's payment or denial notification (typically, the explanation of benefits or remittance advice). Claims submitted for this scenario must include a copy of the primary carrier's payment or denial notification or normal filing limits will be applied to the claim.
- Claims submitted to the Alliance late due to retroactive enrollment changes performed by the State for Medi-Cal members.

Corrections to previously submitted claims must be received in a timely fashion. When a claim is submitted to the Alliance, the Alliance accepts the claim as true and correct and processes the claim based on the information contained on the claim form. Providers and billing services must take care to ensure that claims are correct when initially submitted. When a correction is necessary, the correct claim document along with supporting records must be received by the Alliance with 90 days of our initial claim determination.

Timely filing periods are contained in participating provider's contracts with the Alliance. As such, exceptions to the timely filing contractual requirement are made only in the circumstances described and certain special situations.

To avoid having claims denied for late submission, the Alliance recommends that providers check eligibility prior to rendering non-emergent services. This will help billing staff to know where a claim is to be submitted at the time of initial bill preparation. The Alliance provides medical staff with many convenient ways to check eligibility including:

- Automated Eligibility Verification System (AEVS)
- IDiamond Secure Web Services
- Enrollment Verification Phone Number

If you don't utilize these services and are interested in learning more about them, contact the Provider Services department at 510-747-4508.

### VERIFYING RECEIPT OF CLAIMS

CCR Title 28, section 1300.71 requires the Alliance to acknowledge receipt of a claim (whether or not the claim was complete):

- Within two (2) working days of the date of the receipt of an electronic claim. The Alliance provides an electronic notification for all electronic claims that are received by our Claims department.
- Within fifteen (15) working days of the date of the receipt of a paper claim. The Alliance provides IDIAMOND Web services that allow providers to track receipt of submitted claims. In addition, providers may contact the Alliance's Claims department to verify receipt as well.

If a provider feels that claims are not being received by the Alliance, we suggest taking advantage of these available acknowledgement methods to verify receipt of submitted claims.

If you cannot verify receipt of a submitted claim through the methods outlined above within 20 days from the date that you submitted the claim, contact the Claims department for instruction. In most cases, we will verify the address to which you submitted the claim and ask you to submit another claim. This process will allow ample time to file the claim again and still be well within the timely filing period.

### SUBMITTING CLAIMS OUTSIDE OF THE FILING PERIOD

If a claim is submitted outside of the contractual and/or regulatory timeframes, proper documentation showing the reason why the claim is being submitted late must be attached to the late claim. Acceptable proof of timely filing waiver includes:

- ✓ Certified mail receipt proving claims were received by the Alliance.
- ✓ Copy of the Remittance Advice or Evidence of Benefits (EOB) from the primary payer indicating the date of resolution (payment, date of contest, denial, or notice) when the claim was denied for timely EOB.
- ✓ Copy of the Alliance's Electronic Data Interchange (EDI) Preprocessing Error Report for claims originally submitted electronically.
- ✓ Copy of the Alliance's Remittance Advice (RA) indicating the date and reason for the original denial when a claim was denied for incomplete reasons.
- ✓ Documentation of the cause for the delay in submitting a claim to the Alliance when the provider experiences exceptional circumstances beyond his/her control.

Beginning with claims received as of October 1, 2007, the Alliance will no longer accept computer printouts or other documents from providers' billing systems to document proof of submission. The Alliance cannot be familiar with each provider's billing software nor can the Alliance properly evaluate those documents with reasonable fairness to both parties.

Please refer to the Provider Manual for correct claims submission addresses. If you have any questions about where to send a claim, the information can be obtained from the back of the member's identification card or by contacting the Alliance Claims department at 510-747-4530.

For further information, please feel free to contact Provider Services at 510-747-4510 or email the department at [providerservices@alamedaalliance.org](mailto:providerservices@alamedaalliance.org).