KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Claims Timely Filing	**Policy #**	6.42-P
Policy Owner	Claims	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/06/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

A. The purpose of this policy is to establish guidelines for the timely submission and acceptance of claims for processing in compliance with Centers for Medicare & Medicaid Services (CMS). This policy is designed to ensure that Kern Family Health Care (KHS) is compliant with timely filing standards for non-contracted providers.

Implementation of this policy seeks to:

1. Minimize financial risk associated with untimely claim filings by preventing payment to providers on claims that were filed outside of the three hundred and sixty-five (365)-day timely filing window followed by Medicare.
2. Maintain claims processing integrity.
3. Promote provider accountability.

II. POLICY

A. This policy applies to all non-contracted provider claims submitted to KHS under the Medicare lines of business. Per CMS, Non-contracted providers must submit initial clean claims within three hundred and sixty-five (365) days of the claim date of service to be considered for payment. Claims submitted outside of this timeframe, excluding those where timely filing is being waived as an administrative decision, must be denied for not being submitted in the timely filing window.

Administrative exceptions may include, but are not limited to:

1. Retroactive Medicare Eligibility
2. Administrative error on the part of KHS

The claims processing system must be set up so claims that fall outside of the three hundred and sixty-five (365)-day timely filing window are automatically denied without manual intervention.

Claim denial notifications must include standard information on a provider's right to appeal a claim denied for timely filing and go through the normal appeal process. Providers are responsible for ensuring that all claims are submitted within the timely filing window and that they are clean and include all necessary information required to process.

The timely filing window for non-contracted providers begins on the day the service was rendered.

Example: Dr. Smith, a non-contracted provider, treats a KHS Medicare Advantage (MA) plan enrollee on December 12th, 2024. Per CMS guidelines, Dr. Smith can submit a clean claim to KHS by December 12th, 2025, for it to be considered for payment.

The three hundred and sixty-five (365)-day timely filing only applies to non-contracted providers. Contracted providers timely filing is determined by the provisions in the Provider Manual for contracted providers, or the timely filing window listed within the provider's specific provider agreement.

Providers are requested to immediately notify KHS if they experience issues that prevent them from submitting their claims in a timely manner.

As part of the monitoring and oversight, KHS is required to track the timeliness of claims submissions and report on any claims that were paid outside of the timely filing window that were not the result of administrative decisions or reprocessing efforts due to special projects.

III. DEFINITIONS

TERMS	DEFINITIONS
Clean Claim	A claim that includes all required information necessary to adjudicate and determine payer liability. In addition to the claim form, necessary information can include, but is not limited to, necessary consents, releases, assignments, medical records, or other information necessary to determine the medical necessity of the services provided.
CMS	Centers for Medicare & Medicaid Services, the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.
D-SNP/SNP	Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.
Medicare Advantage (MA)	Medicare Advantage Plans are another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D).

Non-contracted Provider	A provider or supplier that does not contract with the Medicare Advantage plan to provide services covered by the MA plan.
Timely Filing Limit	The CMS mandated timeframe in which claims from non-contracted providers must be submitted to be considered for payment, typically twelve (12) months or three hundred and sixty-five (365) days from the date of service on the claim.

IV. PROCEDURES

Claims that are past the timely filing limit will be denied. An Explanation of Provider Payment will indicate to the provider why the claim is denied.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	42 Code of Federal Regulations (CFR) § 424.44 Time limits for filing claims

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	Claims

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
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Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
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