Cal. Admin. Code tit. 28, § 1300.71

Barclays Official California Code of Regulations Currentness
Title 28. Managed Health Care
Division 1. The Department of Managed Health Care
Chapter 2. Health Care Service Plans
Article 8. Self-Policing Procedures (Refs & Annos)

§ 1300.71. Claims Settlement Practices.

(a) Definitions.

(1) "Automatically" means the payment of the interest due to the provider within five (5) working days of the payment of the claim without the need for any reminder or request by the provider.

(A) If the interest payment is not sent in the same envelope as the claim payment, the plan or the plan's capitated provider shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim and document the specific interest payment made for each claim.

(B) In the event that the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, a plan or plan's capitated provider that pays claims (hereinafter referred to as "the plan's capitated provider") may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid, provided the plan or the plan's capitated provider includes with the interest payment a statement identifying the specific claims for which the interest is paid, setting forth the method for calculating interest on each claim and documenting the specific interest payment made for each claim.

(2) "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined by section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11 and:

(A) For emergency services and care provider claims as defined by section 1371.35(j):

(i) the information specified in section 1371.35(c) of the Health and Safety Code; and

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(ii) any state-designated data requirements included in statutes or regulations.

(B) For institutional providers:

(i) the completed UB 92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;

(ii) entries stated as mandatory by NUBC and required by federal statute and regulations; and

(iii) any state-designated data requirements included in statutes or regulations.

(C) For dentists and other professionals providing dental services:

(i) the form and data set approved by the American Dental Association;

(ii) Current Dental Terminology (CDT) codes and modifiers; and

(iii) any state-designated data requirements included in statutes or regulations.

(D) For physicians and other professional providers:

(i) the Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format;

(ii) Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes;

(iii) entries stated as mandatory by NUCC and required by federal statute and regulations; and

(iv) any state-designated data requirements included in statutes or regulations.

(E) For pharmacists:

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(i) a universal claim form and data set approved by the National Council on Prescription Drug Programs; and

(ii) any state-designated data requirements included in statutes or regulations.

(F) For providers not otherwise specified in these regulations:

(i) A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and

(ii) any state-designated data requirements included in statutes or regulations.

(3) “Reimbursement of a Claim” means:

(A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;

(B) For contracted providers without a written contract and non-contracted providers,except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:(1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.

(4) “Date of contest,” “date of denial” or “date of notice” means the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

(5) “Date of payment” means the date of postmark or electronic mark accurately setting

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forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

(6) “Date of receipt” means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the “date of receipt” shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

(7) “Date of Service,” for the purposes of evaluating claims submission and payment requirements under these regulations, means:

(A) For outpatient services and all emergency services and care: the date upon which the provider delivered separately billable health care services to the enrollee.

(B) For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a plan and a plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.

(8) A “demonstrable and unjust payment pattern” or “unfair payment pattern” means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The following practices, policies and proceduresmay constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a “demonstrable and unjust payment pattern” as set forth in section (s)(4):

(A) The imposition of a Claims Filing Deadline inconsistent with section (b)(1) in three (3) or more claims over the course of any three-month period;

(B) The failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three-month period;

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(C) The failure to accept a late claim consistent with section (b)(4) at least 95% of the time for the affected claims over the course of any three-month period;

(D) The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period;

(E) The failure to acknowledge the receipt of at least 95% of claims consistent with section (c) over the course of any three-month period;

(F) The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period;

(G) The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as defined by section (a)(10), for the adjudication of a claim on three (3) or more occasions over the course of any three month period;

(H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

(J) The failure to include the mandated contractual provisions enumerated in section (e) in three (3) or more of its contracts with either claims processing organizations and/or with plan's capitated providers over the course of any three-month period;

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(K) The failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period;

(L) The failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period;

(M) The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required by sections (l) and (o) to three (3) or more contracted providers over the course of any three-month period;

(N) The failure to provide three (3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and Other Required Information consistent with section (m) over the course of any three month period;

(O) Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with section (p) on three (3) or more occasions over the course of any three month period;

(P) The failure to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims over the course of any three-month period;

(Q) The imposition of a provider dispute filing deadline inconsistent with section 1300.71.38(d) in three (3) or more affected claims over the course of any three-month period;

(R) The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period;

(S) The failure to comply with the Time Period for Resolution and Written Determination enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period; and

(T) An attempt to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization, inconsistent with section 1371.8, on three (3) or more occasions over the course of any three-

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month period.

(9) “Health Maintenance Organization” or “HMO” means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).

(10) “Reasonably relevant information” means 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 with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(11) “Information necessary to determine payer liability” means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(12) “Plan” for the purposes of this section means a licensed health care service plan and its contracted claims processing organization.

(13) “Working days” means Monday through Friday, excluding recognized federal holidays.

(b) Claim Filing Deadline.

(1) Neither the plan nor the plan's capitated provider that pays claims shall impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If a plan or a plan's capitated provider is not the primary payer under coordination of benefits, the plan or the plan's capitated provider shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.

(2) If a claim is sent to a plan that has contracted with a capitated provider that is responsible for adjudicating the claim, then the plan shall do the following:

(A) For a provider claim involving emergency service and care, the plan shall forward

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the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan.

(B) For a provider claim that does not involve emergency service or care: (i) if the provider that filed the claim is contracted with the plan's capitated provider, the plan within ten (10) working days of the receipt of the claim shall either: (1) send the claimant a notice of denial, with instructions to bill the capitated provider or (2) forward the claim to the appropriate capitated provider; (ii) in all other cases, the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.

(3) If a claim is sent to the plan's capitated provider and the plan is responsible for adjudicating the claim, the plan's capitated provider shall forward the claim to the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan's capitated provider.

(4) A plan or a plan's capitated provider that denies a claim because it was filed beyond the claim filing deadline, shall, upon provider's submission of a provider dispute pursuant to section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to Health and Safety Code section 1371 or 1371.35, which ever is applicable, and these regulations.

(5) A plan or a plan's capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the over paid claim. The written notice shall include the information specified in section (d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

(c) Acknowledgement of Claims. The plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt as defined by section 1300.71(a)(6) in the same manner as the claim was submitted or provide an electronic means, by phone, website, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the plan's or the plan's capitated provider's receipt of the claim and the recorded date of receipt as defined by 1300.71(a)(6) as follows:

(1) In the case of an electronic claim, identification and acknowledgement shall be provided within two (2) working days of the date of receipt of the claim by the office designated to receive the claim, or

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(2) In the case of a paper claim, identification and acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the claim by the office designated to receive the claim.

(A) If a claimant submits a claim to a plan or a plan's capitated provider using a claims clearinghouse, the plan's or the plan's capitated provider's identification and acknowledgement to the clearinghouse within the timeframes set forth in subparagraphs (1) or (2), above, whichever is applicable, shall constitute compliance with this section.

(d) Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Claims.

(1) A plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

(2) In the event that the plan or the plan's capitated provider requests reasonably relevant information from a provider in addition to information that the provider submits with a claim, the plan or plan's capitated provider shall provide a clear, accurate and written explanation of the necessity for the request. If the plan or the plan's capitated provider subsequently denies the claim based on the provider's failure to provide the requested medical records or other information, any dispute arising from the denial of such claim shall be handled as a provider dispute pursuant to Section 1300.71.38 of title 28.

(3) If a plan or a plan's capitated provider determines that it has overpaid a claim, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

(4) If the provider contests the plan's or the plan's capitated provider's notice of reimbursement of the overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, shall send written notice to the plan or the plan's capitated provider stating the basis upon which the provider believes that the claim was not over paid. The plan or the plan's capitated provider shall receive and process the contested notice of overpayment of a claim as a provider dispute pursuant to Section 1300.71.38 of title 28.

(5) If the provider does not contest the plan's or the plan's capitated provider's notice of reimbursement of the overpayment of a claim, the provider shall reimburse the plan or the

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plan's capitated provider within 30 working days of the receipt by the provider of the notice of overpayment of a claim.

(6) A plan or a plan's capitated provider may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse the plan or the plan's capitated provider within the timeframe of section (5) above and (ii) the provider has entered into a written contract specifically authorizing the plan or the plan's capitated provider to offset an uncontested notice of overpayment of a claim from the contracted provider's current claim submissions. In the event that an overpayment of a claim or claims is offset against a provider's current claim or claims pursuant to this section, the plan or the plan's capitated provider shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

(e) Contracts for Claims Payment. A plan may contract with a claims processing organization for ministerial claims processing services or contract with capitated providers that pay claims, (“plan's capitated provider”) subject to the following conditions:

(1) The plan's contract with a claims processing organization or a capitated provider shall obligate the claims processing organization or the capitated provider to accept and adjudicate claims for health care services provided to plan enrollees in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

(2) The plan's contract with the capitated provider shall require that the capitated provider establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28, unless the plan assumes this function.

(3) The plan's contract with a claims processing organization or a capitated provider shall require:

(i) the claims processing organization and the capitated provider to submit a Quarterly Claims Payment Performance Report (“Quarterly Claims Report”) to the plan within thirty (30) days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose the claims processing organization's or the capitated provider's compliance status with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28;

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(ii) the capitated provider to include in its Quarterly Claims Report a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received. Each individual dispute contained in a provider's bundled notice of provider dispute shall be reported separately to the plan; and

(iii) that each Quarterly Claims Report be signed by and include the written verification of a principal officer, as defined by section 1300.45(o), of the claims processing organization or the capitated provider, stating that the report is true and correct to the best knowledge and belief of the principal officer.

(4) The plan's contract with a capitated provider shall require the capitated provider to make available to the plan and the Department all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

(5) The plan's contract with a capitated provider shall provide that any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process for ade novo review and resolution for a period of 60 working days from the capitated provider's Date of Determination, pursuant to the provisions of section 1300.71.38(a)(4) of title 28.

(6) The plan's contract with a claims processing organization or the capitated provider shall include provisions authorizing the plan to assume responsibility for the processing and timely reimbursement of provider claims in the event that the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties). The plan's obligation to assume responsibility for the processing and timely reimbursement of a capitated provider's provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code.

(7) The plan's contract with the capitated provider shall include provisions authorizing a plan to assume responsibility for the administration of the capitated provider's dispute resolution mechanism(s) and for the timely resolution of provider disputes in the event that the capitated provider fails to timely resolve its provider disputes including the issuance of a written decision.

(8) The plan's contract with a claims processing organization or a capitated provider shall not relieve the plan of its obligations to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

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(f) Disclosures.

(1) A plan or a plan's capitated provider, with the agreement of the contracted provider, may utilize alternate transmission methods to deliver any disclosure required by this regulation so long as the contracted provider can readily determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

(2) To the extent that the Health Insurance Portability and Accountability Act of 1996, as amended, limits the plan's or the plan's capitated provider's ability to electronically transmit any required disclosures under this regulation, the plan or the plan's capitated provider shall supplement its electronic transmission with a paper communication that satisfies the disclosure requirements.

(g) Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

(1) To the extent that a full service health care service plan that meets the definition of an HMO as set forth in paragraph 1300.71(a)(9) also maintains a PPO or POS line of business, the plan shall reimburse all claims relating to or arising out of non-HMO lines of business within thirty (30) working days.

(2) If a specialized health care service plan contracts with a plan that is a health maintenance organization to deliver, furnish or otherwise arrange for or provide health care services for that plan's enrollees, the specialized plan shall reimburse complete claims received for those services within thirty (30) working days.

(3) If a non-contracted provider disputes the appropriateness of a plan's or a plan's capitated provider's computation of the reasonable and customary value, determined in accordance with section (a)(3)(B), for the health care services rendered by the non-contracted provider, the plan or the plan's capitated provider shall receive and process the non-contracted provider's dispute as a provider dispute in accordance with section 1300.71.38.

(4) Every plan contract with a provider shall include a provision stating that except for applicable co-payments and deductibles, a provider shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement

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paid by the plan or the plan's capitated provider for any covered benefit.

(h) Time for Contesting or Denying Claims. A plan and a plan's capitated provider may contest or deny a claim, or portion thereof, by notifying the provider, in writing, that the claim is contested or denied, within thirty (30) working days after the date of receipt of the claim by the plan and the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the claim by the plan or the plan's capitated provider.

(1) To the extent that a full service health care service plan that meets the definition of an HMO as set forth in paragraph 1300.71(a)(9) also maintains a PPO or POS line of business, the plan shall contest or deny claims relating to or arising out of non-HMO lines of business within thirty (30) working days.

(2) If a specialized health care service plan contracts with a plan that is a health maintenance organization to deliver, furnish or otherwise arrange for or provide health care services for that plan's enrollees, the specialized plan shall contest or denied claims received for those services within thirty (30) working days.

(3) A request for information necessary to determine payer liability from a third party shall not extend the Time for Reimbursement or the Time for Contesting or Denying Claims as set forth in sections (g) and (h) of this regulation. Incomplete claims and claims for which “information necessary to determine payer liability” that has been requested, which are held or pended awaiting receipt of additional information shall be either contested or denied in writing within the timeframes set forth in this section. The denial or contest shall identify the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability

(i) Interest on the Late Payment of Claims.

(1) Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

(2) Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.

(j) Penalty for Failure to Automatically Include the Interest Due on a Late Claim Payment as set forth in section (i). A plan or a plan's capitated provider that fails to automatically

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include the interest due on a late claim payment shall pay the provider $10 for that late claim in addition to any amounts due pursuant to section (i).

(k) Late Notice or Frivolous Requests. If a plan or a plan's capitated provider fails to provide the claimant with written notice that a claim has been contested or denied within the allowable time period prescribed in section (h), or requests information from the provider that is not reasonably relevant or requests information from a third party that is in excess of the information necessary to determine payor liability as defined in section (a)(11), but ultimately pays the claim in whole or in part, the computation of interest or imposition of penalty pursuant to sections (i) and (j) shall begin with the first calendar day after the expiration of the Time for Reimbursement as defined in section (g).

(l) Information for Contracting Providers. On or before January 1, 2004, (unless the plan and/or the plan's capitated provider confirms in writing that current information is in the contracted provider's possession), initially upon contracting and in addition, upon the contracted provider's written request, the plan and the plan's capitated provider shall disclose to its contracting providers the following information in a paper or electronic format, which may include a website containing this information, or another mutually agreeable accessible format:

(1) Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation consistent with section (a)(10), instructions for confirming the plan's or the plan's capitated provider's receipt of claims consistent with section (c), and a phone number for claims inquiries and filing information;

(2) The identity of the office responsible for receiving and resolving provider disputes;

(3) Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of provider disputes and all claim dispute requirements, the timeframe for the plan's and the plan's capitated provider's acknowledgement of the receipt of a provider dispute and a phone number for provider dispute inquiries and filing information; and

(4) Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled notice.

(m) Modifications to the Information for Contracting Providers and to the Fee Schedules and Other Required Information. A plan and a plan's capitated provider shall provide a

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minimum of 45 days prior written notice before instituting any changes, amendments or modifications in the disclosures made pursuant to paragraphs (l) and (o).

(n) Notice to the Department. Within 7 calendar days of a Department request, the plan and the plan's capitated providers shall provide a pro forma copy of the plan's and the plan's capitated provider's “Information to Contracting Providers” and “Modification to the Information for Contracting Providers.”

(o) Fee Schedules and Other Required Information. On or before January 1, 2004, (unless the plan and/or the plan's capitated provider confirms in writing that current information is in the contracted provider's possession), initially upon contracting, annually thereafter on or before the contract anniversary date, and in addition upon the contracted provider's written request, the plan and the plan's capitated provider shall disclose to contracting providers the following information in an electronic format:

(1) The complete fee schedule for the contracting provider consistent with the disclosures specified in section 1300.75.4.1(b); and

(2) The detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims, which shall, unless otherwise prohibited by state law:

(A) when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations;

(B) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and

(C) at a minimum, clearly and accurately state the policies regarding the following: (i) consolidation of multiple services or charges, and payment adjustments due to coding changes, (ii) reimbursement for multiple procedures, (iii) reimbursement for assistant surgeons, (iv) reimbursement for the administration of immunizations and injectable medications, and (v) recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience and competence in claims processing can determine the payment to be made according to the terms of the contract.

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A plan or a plan's capitated provider may disclose the Fee Schedules and Other Required Information mandated by this section through the use of a website so long as the plan or the plan's capitated provider provides written notice to the contracted provider at least 45 days prior to implementing a website transmission format or posting any changes to the information on the website.

(p) Waiver Prohibited. The plan and the plan's capitated provider shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed upon the plan by sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28, relating to claims processing or payment. Any contractual provision or other agreement purporting to constitute, create or result in such a waiver is null and void.

(q) Required Reports.

(1) Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department in a single combined document: (A) any emerging patterns of claims payment deficiencies; (B) whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95% of its claims (including the payment of interest and penalties) consistent with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28; and (C) the corrective action that has been undertaken over the preceding two quarters. The first report from the plan shall be due within 45 days after the close of the calendar quarter that ends 120 days after the effective date of these regulations.

(2) Within 15 days of the close of each calendar year, beginning with the 2004 calendar year, the plan shall submit to the Director, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report as specified in section 1367(h) of the Health and Safety Code and section 1300.71.38(k) of title 28, in an electronic format (to be supplied by the Department), information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers with each of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. The Annual Plan Claims Payment and Dispute Resolution Mechanism Report for 2004 shall include claims payment and dispute resolution data received from October 1, 2003 through September 30, 2004. Each subsequent Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall include claims payment and dispute resolution data received for the last calendar quarter of the year preceding the reporting year and the first three calendar quarters for the reporting year.

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(A) The claims payment compliance status portion of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall: (i) be based upon the plan's claims processing organization's and the plan's capitated provider's Quarterly Claims Payment Performance Reports submitted to the plan and upon the audits and other compliance processes of the plan consistent with section 1300.71.38(m) and (ii) include a detailed, informative statement: (1) disclosing any established or documented patterns of claims payment deficiencies, (2) outlining the corrective action that has been undertaken, and (3) explaining how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results). The information provided pursuant to this section shall be submitted with the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant to section 1007 of title 28.

(r) Confidentiality.

The claims payment compliance status portion of the plan's Annual Plan Claims Payment and Dispute Resolution Mechanism Report and the Quarterly disclosures pursuant to section (q)(1) to the Department shall be public information except for information disclosed pursuant to section (q)(2)(A)(ii), that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(s) Review and Enforcement.

(1) The Department may review the plan's and the plan's capitated provider's claims processing system through periodic medical surveys and financial examinations under sections 1380, 1381 or 1382 of the Health and Safety Code, and when appropriate, through the investigation of complaints of demonstrate and unjust payment patterns.

(2) Failure of a plan to comply with the requirements of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28 may constitute a basis for disciplinary action against the plan. The civil, criminal, and administrative remedies available to the Director under the Health and Safety Code and this regulation are not exclusive, and may be sought and employed in any combination deemed advisable by the Director to enforce the provisions of this regulation.

(3) Violations of the Health and Safety Code and this regulation are subject to enforcement action whether or not remediated, although a plan's identification and self-initiated remediation of deficiencies may be considered in determining the appropriate penalty.

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(4) In making a determination that a plan's or a plan's capitated provider's practice, policy or procedure constitutes a “demonstrable and unjust payment pattern” or “unfair payment pattern,” the Director shall consider the documentation or justification for the implementation of the practice, policy or procedure and may consider the aggregate amount of money involved in the plan's or the plan's capitated provider's action or inaction; the number of claims adjudicated by the plan or plan's capitated provider during the time period in question, legitimate industry practices, whether there is evidence that the provider had engaged in an unfair billing practice, the potential impact of the payment practices on the delivery of health care or on provider practices; the plan's or the plan's capitated provider's intentions or knowledge of the violation(s); the speed and effectiveness of appropriate remedial measures implemented to ameliorate harm to providers or patients, or to preclude future violations; and any previous related or similar enforcement actions involving the plan or the plan's capitated provider.

(5) Within 30 days of receipt of notice that the Department is investigating whether the plan's or the plan's capitated provider's practice, policy or procedure constitutes a demonstrable and unjust payment pattern, the plan may submit a written response documenting that the practice, policy or procedure was a necessary and reasonable claims settlement practice and consistent with sections 1371, 1371.35 and 1371.37 of the Health and Safety Code and these regulations;

(6) In addition to the penalties that may be assessed pursuant to section (s)(2), a plan determined to be engaged in a Demonstrable and Unjust Payment Pattern may be subject to any combination of the following additional penalties:

(A) The imposition of an additional monetary penalty to reflect the serious nature of the demonstrable and unjust payment pattern;

(B) The imposition, for a period of up to three (3) years, of a requirement that the plan reimburse complete and accurate claims in a shorter time period than the time period prescribed in section (g) of this regulation and sections 1371 and 1371.35 of the Health and Safety Code; and

(C) The appointment of a claims monitor or conservator to supervise the plan's claim payment activities to insure timely compliance with claims payment obligations.

The plan shall be responsible for the payment of all costs incurred by the Department in any administrative and judicial actions, including the cost to monitor the plan's and the plan's capitated provider's compliance.

(t) Compliance. Plans and the plans' capitated providers shall be fully compliant with

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these regulations on or before January 1, 2004.

Note: Authority cited: Sections 1344, 1371.38, 1371.1 and 1371.8, Health and Safety Code. Reference: Sections 1367, 1370 and 1371.38, Health and Safety Code.

HISTORY

1. New section filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30). For prior history of title 10, section 1300.71, see Register 80, No. 19.

28 CCR § 1300.71, 28 CA ADC § 1300.71

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