

**DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28, SECTIONS 1300.71 AND 1300.71.38**

INITIAL STATEMENT OF REASONS:

**CLAIMS SETTLEMENT PRACTICES AND
DISPUTE RESOLUTION MECHANISMS**

(2002-REG-10)

As required by section 11346.2 of the Government Code, the Director of the Department of Managed Health Care (Director) sets forth below the reasons for the proposed adoption of sections 1300.71 and 1300.71.38, Title 28, California Code of Regulations.

Pursuant to Health and Safety Code section 1341.9, the Department is vested with all duties, powers, purposes, responsibilities and jurisdiction as they pertain to health care service plans and the health care service plan business.

The adoption of California Code of Regulations, Title 28, section 1300.71 is necessary to clearly define terms relating to claim settlement and reimbursement, and provide procedures for plans and providers to prevent unreasonable delays in payment of provider claims. Additionally, this section clarifies the meaning of unfair payment practices and the term "complete and accurate claim." Furthermore, this section requires that no plan contract shall require or allow any provider to waive any right conferred by the Knox-Keene Health Care Service Plan Act of 1975 (Act) or this section.

Pursuant to Health and Safety Code section 1371.38, the adoption of California Code of Regulations section 1300.71.38 provides for a fair, fast and cost-effective provider dispute resolution mechanism for resolving billing, claim, and other contract disputes. This process provides a mechanism for resolving billing and claim disputes directly or indirectly involving the plan or its enrollees voluntarily submitted by contracting and non-contracting providers.

Timely reimbursements of provider claims are necessary to ensure a stable and financially viable health care delivery system. Unreasonable delays by plans to settle provider claims results in unnecessary expenditure of personnel time and energy by providers in their repeated attempts to get claims paid. These resources would be better spent on providing quality health care services to enrollees. Furthermore, unpaid claims result in excessive financial burdens on doctors, hospitals and other providers.

SPECIFIC PURPOSE OF THE REGULATION

Section 1300.71 (a)(1) is necessary to define the term "automatically" as that term is used throughout the regulation.

Section 1300.71(a)(2) is necessary to define the term "complete claim" as that term is used throughout the regulation.



Section 1300.71(a)(9) is necessary to define and clarify the term "information necessary to determine payor liability" and "reasonably relevant information" as that term is used throughout the regulation.

Section 1300.71(a)(10) is necessary to define the term "medical records in the control of provider" as that term is used throughout the regulation and to clarify when medical records shall be presumed not to be necessary to determine payor liability.

Section 1300.71(a)(11) is necessary to define the term "working days" as that term is used throughout the regulation.

Section 1300.71(b)(1) clarifies the time requirements regarding claim filing deadlines set forth by plans.

Section 1300.71(b)(2) clarifies that plans are required to forward to the appropriate capitated provider or claims processing organization within a specified time, any claims incorrectly sent to the plan.

Section 1300.71(b)(3) clarifies that the date of payment or date of notice from the primary payor activates the time period for submitting supplemental or coordination of benefit claims to any secondary payors, if a plan is not the primary payor under coordination of benefits.

Section 1300.71(b)(4) mandates that plans shall accept, process, and if appropriate pay claims that were denied as untimely if the provider submits a provider dispute and shows good cause.

Section 1300.71(c) is necessary to explain how and when plans shall enter each claim submission into its system and further explains how plans shall provide acknowledgment of receipt of claims.

Section 1300.71(c)(1) clarifies the time requirements for plans entering claims into their systems specifically for claims filed electronically with the office designated to receive claims.

Section 1300.71(c)(2) clarifies the time requirements for plans entering claims into their systems specifically for paper claims received by the office designated to receive claims.

Section 1300.71(d) states that plans shall not unreasonably deny, adjust or contest a claim and clarifies that plans are required to provide an accurate and clear explanation of the reasons for any claim that a plan denies, adjusts or contests.

Section 1300.71(e) explains that plans may contract for ministerial claim processing services with a claims processing organization or delegate claim payment responsibility to capitated providers if the specified conditions listed below are satisfied.

Section 1300.71(e)(1) clarifies the requirement that the contracts with claim processing service organizations or delegated capitated providers shall obligate the parties to process and



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FINAL STATEMENT OF REASONS
(Government Code section 11346.9)

CLAIMS SETTLEMENT PRACTICES AND
DISPUTE RESOLUTION MECHANISMS
(2002-REG-10)

Amendments to Informative Digest:

The Department has no amendments to the Informative Digest. Though some text modifications have taken place during the rulemaking for clarity and precision, the reasoning behind the text has remained the same.

Amendments to Initial Statement of Reasons:

Section 1300.71 (a)(1) is necessary to define the term "automatically" as that term is used throughout the regulation. The revised definition allows monthly reimbursement for interest payments of less than \$2.00 so that the cost of processing and depositing the interest check does not exceed the value of the interest payment

Section 1300.71(a)(2) is necessary to define the term "complete claim" as that term is used throughout the regulation. The revisions were adopted to better delineate the minimum amount of information necessary to adjudicate a complete claim.

Section 1300.71 (a)(2)(C)(i) - (ii) clarifies the term "complete claim" specifically for dentists as that term is used throughout the regulation. The definition was revised to include other professionals providing dental services that are likely to utilize the same billing formats and Current Dental Terminology Codes that are the billing standards use in the dental industry.

Section 1300.71 (a)(2)(F)(i) - (ii) clarifies the term "complete claim" for providers not otherwise specified throughout the regulation. The revisions reflect a reorganization of the definition. The deleted terms have been inserted above in section 1300.71(a)(2)

The new Section 1300.71 (a)(3) is necessary to define what constitutes reimbursement of a claim for the purposes of Sections 1371 and 1371.35. This definition is not intended to alter or change existing California law or to establish specific reimbursement rates.

Defining the appropriate calculation of reimbursement for contracted provider claims for providers that maintain written contracts with the payor is straight forward as the parties' written agreement controls reimbursement. Non-contracted providers or providers without a written contract involve more subjective considerations. The definition adopted in this regulation is designed to reiterate current California law as embodied in *Gould v. Worker's Compensation Appeals Board, City of Los Angeles* (1992) 4 Cal. App. 4th 1059; 6 Cal. Rptr. 2d 228. That case



Section 1300.71(b)(2) was revised to better clarify the plan's obligations to forward misdirected claims to the appropriate capitated provider within the timeframes specified in Section 1300.71(b)(2)(A)-(B).

For clarity purposes, the original Section 1300.71(b)(3) relating to coordination of benefits has been relocated to Section 1300.71(b)(1) and clarifies that the deadline for submitting supplemental or coordination of benefit claims to any secondary payors, if a plan is not the primary payor under coordination of benefits.

Section 1300.71(b)(3) clarifies the obligation of a plan's capitated provider to forward misdirected claims to the plan and is necessary to ensure that a plan's capitated provider promptly forward misdirected claims to the plan for adjudication

Section 1300.71(b)(4) was revised for greater clarity. The section mandates that plans and the plan's capitated provider accept and adjudicate late claims submissions according to Section 1371.1 and 1371.35, that were denied as untimely if the provider submits a provider dispute and demonstrates good cause for the delay.

Section 1300.71(b)(5) was added to set forth the maximum time frame to assert requests for reimbursement of overpayment of claims. This section was necessary to ensure that plans and plans' capitated providers do not engage in unfair payment patterns in violation of Health & Safety Section 1371.1

Section 1300.71(c) has been renamed Acknowledgement of Claims. The clarifications are necessary to explain how and when payors shall enter each claim submission into its system and further explains how the payor shall provide acknowledgment of receipt of claims. The revisions were necessary to provide greater clarity and to provide the flexibility for the differences in information systems.

Section 1300.71(c)(1) was revised to provide greater clarity regarding the time requirements for plans entering electronic claims into their systems. .

Section 1300.71(c)(2) was revised to provide greater clarity regarding the time requirements for plans entering paper claims into their systems

Section 1300.71(c)(2)(A) was added and is necessary to explain how the timeframes will be counted when a provider utilizes the services of a claims clearing house to process claims.

Section 1300.71(d)(1) was revised for greater clarity to state that plans and the plans' capitated provider shall not improperly deny, adjust or contest a claim and clarifies and that plans and the plans' capitated providers are required to provide an accurate and clear explanation of the specific reasons for the action taken on any claim that is denied, adjusted or contested.

Section 1300.71(d)(2) was added and is necessary to set forth the payor's obligation to explain, in writing, its need to request added information in order to properly adjudicate a claim



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RESPONSES TO COMMENTS
First Comment Period**

COMMENTS		DEPARTMENT RESPONSE	
82	Paragraph 4: Rather than require the provider to show good cause why the claims should be accepted, the plan should be required to show actual prejudice from the delay if it wants to avoid accepting the claim.	REJECT: Inverting the burden of proof by requiring the payor to demonstrate actual prejudice would be inconsistent with the purpose of Sections 1371 and 1371.35 and the entire regulatory scheme which is to facilitate the prompt payment of claims.	
83	Paragraph 4: Section 1300.71(b)(4) states that a provider who has a late claim can submit it if the provider shows good cause. For clarity purposes, recommend deleting, "and a showing of good cause" and inserting at the end of line three "unless the plan can provide good cause for denying the claim."	REJECT: See # 82	
84	It is unclear whether claims that the provider delayed submitting because they were previously considered a worker's compensation or personal injury case would qualify as a "good cause."	REJECT: See # 81.	
85	If the provider uses an electronic clearinghouse to submit claims acknowledgement of claim submission to the clearinghouse should constitute acknowledgement to the provider. When a clearinghouse is used, the plan's confirmation is also submitted to the clearinghouse, not directly to the provider. This issue should be acknowledged in the language.	ACCEPT: This concept is included in the revised regulations.	
86	Recommend defining "date of receipt" as defined in	ACCEPTED, IN PART: These concepts	



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COMMENTS	DISPUTE RESOLUTION	
	1300.71(a)(5). Moreover, the law requires that plans implement procedures that permit the determination of the date of receipt. (§1300.77).	are included in revised regulation.
87	Recommend requiring plans to acknowledge receipt of claims within one working day for electronic submissions, and three working days for paper.	REJECT: The timeframes included in this regulation requested are reasonable considering the information technology systems generally employed by the plans. Imposing a 1-day acknowledgement deadline is too restrictive.
88	Recommend deleting the phrase “whether or not complete” and inserting the term “complete” before “claim” on line 4, page 6.	REJECT, IN PART: The “whether or not complete” has been deleted, however the Department has determined that even incomplete claims should be logged by the plan if the claims submission meet a certain threshold of data.
89	Recommend deleting subsections (c)(1) and (c)(2) because dictating time periods in detail would have a negative effect on other aspects of claims processing by prioritizing paper claims.	REJECT: The inclusion of a timeframe is important to ensure that claims are paid properly and providers can readily verify that their claims submissions have been received.
90	Section 1300.71(c) requires plans to enter claims into its system within a set number of days of receipt. Recommend expanding definition to apply to a plan’s designated claims processor as well, because providers frequently send claims directly to the plan’s claims processor rather than to the plan.	ACCEPT IN PART: The plan’s decision to utilize a claims processing organization under the revised regulations do not extend the time frame for the prompt payment of claims. The utilization of a claims processing organization is for the benefit of the plan and the notice to its



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	COMMENT	DEPARTMENT RESPONSE
		agent is assumed to be noticed to the plans.
91	Paragraph 1: The timeframes for electronic confirmation of receipt of a claim is not adequate for all claims to be uploaded. Some claims can't be uploaded quickly due to eligibility and system configuration issues. A more appropriate timeframe would be 15 days for both electronic and paper.	REJECT, IN PART: The timeframe for electronic confirmation of receipt of claim is reasonable and appropriate. The Department recognizes that certain system configuration modifications may be necessary and has therefore provided that the plans need to be fully compliant within 150 days of the effective date of the regulation.
92	Paragraph 2: The 15 working day time period for entering claims in section 1300.71(c)(2) seems excessive. Recommend a time limit of five working days.	REJECT The 15 day period for entering claims was adopted because there is substantially more work involved in inputting paper claims and to create an incentive for providers to submit their claims electronically.
93	Paragraph 3: Section 1300.71(c)(3) should be revised to make the consent ultimately the responsibility of the plan, since the consent of the patient is not always obtainable. The plan has the responsibility for collecting from its enrollee additional information it requires in its consumer grievance process.	ACCEPT: The revised regulations provide that the health plan has the right to verify an enrollee's consent to agreements before processing the claim.
93	Deadlines for entering claims do not comply with HIPAA, which would require claims to be entered only after eligibility is determined. These standards would likely require health plans to adopt new in-house protocols for	NEITHER REJECT NOR ACCEPT: This comment does not request a specific change to the regulations. The Department acknowledges that its



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	information flow.	requirements may differ from federal standards, but that is not a basis to alter the Department's regulatory provisions which are intended to implement California law.
94	Recommend that only complete claims should be entered into the system. Incomplete claims should be pended to ensure all information is received.	REJECT: The Department believes that incomplete claims should be entered into the system so that they can be properly tracked and determine if the plan is inappropriately deeming claims submissions as incomplete claims. Section 1371 does not provide for the "pending" of claims. A plan has responsibility either to accept or reject a claim based upon the information submitted.
95	There should be some threshold that constitutes sufficient information to allow the claim to be tracked.	ACCEPT: The revised regulations enumerate the minimum amount of information before the plan has an obligation to input it into its information systems.
96	Recommend language in section 1300.71(d) stating that the provider should be notified of any adjustments to claims and the patient should be notified when necessary.	REJECT: The current regulations adequately require that the plan notify the provider when a claim is adjusted. There is no reasonable justification for requiring the plan to notify the patient relating to the claims adjudication process.
97	Any denial, adjustment or contested claims should be	NEITHER REJECT NOR ACCEPT: The

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	paper claims, would add significant administrative burden.	are essential to ensuring that complete claims are paid within the statutory time frames.
210	Need to change reference to (d)(3), rather than (d)(4).	ACCEPT: The numbering in the revised text is now accurate.
211	Recommend changing timeframe from 180-day limit to 365-day limit, in line with industry standards and Medicare.	ACCEPT: The regulations have been amended to incorporate the suggested change.
212	180-day time limit is inadequate.	See response to comment # 211. The time limit has been extended to 365 days
213	Plans should be able to include in their provider contracts provisions allowing automatic recovery of overpayments through offsetting against current claim submissions.	ACCEPT: Plans and providers may agree for automatic recovery for uncontested overpayments.
	1300.71(c)(1),(2),(3)	
214	Subdivision (c) requires that claims submitted in paper form be identified and acknowledged electronically. We do not believe that it is feasible for health plans to acknowledge in an electronic format claims submitted in a paper medium. Recommend that subdivision (c)(2) be revised to omit the word "electronically." If the Department desires that <i>electronic</i> claims be acknowledged electronically, this requirement should be moved to subsection (c)(1), such that it does not apply to paper claims.	ACCEPT: The regulation has been revised to incorporate this comment.
215	"Acknowledge electronically" is unclear—system entry or disclosure to provider? Department's authority for mandating an acknowledgement of receipt of a claim appears questionable under Section 1371, which requires	ACCEPT IN PART: The Department amended the section to require plans to have a system in place to acknowledge claims. The Department believes that



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	only claims processing within a given time frame.	section 1371 clearly provides the authority to require that claims be acknowledged in order to ensure that the claims are paid within the statutory time frames.
216	Requiring provider groups to provide an electronic means of verification by phone, website, or other method would be very costly.	REJECT: It is not prohibitively expensive to establish systems to acknowledge electronic claims simultaneously with their receipt. Therefore the two-day timeframe is adequate and appropriate.
217	Five working days would be more reasonable (Section 1300.71(c)(1)).	REJECT: It is not prohibitively expensive to establish systems to acknowledge electronic claims simultaneously with their receipt. Therefore the two-day timeframe is adequate and appropriate.
218	Change two working days to 15 working days (Section 1300.71(c)(1)).	REJECT: It is not prohibitively expensive to establish systems to acknowledge electronic claims simultaneously with their receipt. Therefore the two-day timeframe is adequate and appropriate.
219	Subdivision (c)(2) would require plans to acknowledge the receipt of each claim through a means by which providers can confirm receipt—either electronically, by telephone, website or “ <i>another mutually agreeable method.</i> ” This language implies that each individual provider can unilaterally and for no reason reject electronic mail, telephone or website access and insist upon another means	ACCEPT IN PART: The regulations have been modified to clarify the method for acknowledging claims. The language, another mutually agreeable method, allows a payor to acknowledge the receipt of a claim in a manner that is different than method that the claim was submitted,



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	specific to that particular provider, which may not be economical. It also suggests that the plan must obtain the consent of each and every provider before establishing an alternative method. Recommend that plans should be required to provide reasonable access, but not be required to provide provider-specific mechanisms subject to the consent of each and every provider, in the network or outside of the network.	i.e. electronically, by phone or website. It is only when an alternative method is used that the parties must mutually agree.
220	Recommend deleting requirement to acknowledge the receipt of each claim—unnecessary.	REJECT: The Department believes that it is absolutely essential for plans to acknowledge receipt of claims in order to monitor whether the claims are adjudicated within the statutory time frames and to allow a provider to verify that his claim submission has been received.
221	Recommend that electronic replies be required only for electronic claims. Paper claims often provide no e-mail address or means of communicating electronically.	ACCEPT: The regulations have been revised to accept this comment.
222	In Section 1300.71(c)(5). p. 15, lns. 15-16, change <i>billed item on the invoice to revenue code category on the UB92.</i>	NEITHER ACCEPT NOR REJECT: The referred to subsection has been deleted; therefore, the comment is no longer relevant.
223	Request that provider's name and address be included on list of minimum data elements that must be entered into a claims processing system. Believe that it is not feasible for health plans to	REJECT IN PART, ACCEPT IN PART: see above. The regulations are revised to reflect this change.



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	acknowledge in electronic form claims that are submitted on paper. If Department desires that electronic claims be acknowledged electronically, provision should be moved to subsection (c)(1) so that it does not apply to paper claims.	
224	In Section 1300.71(c), [line 16] add after "identification number" – "In the event that a claim is misdirected based on eligibility to a capitated provider, a capitated provider shall forward a claim to the appropriate plan within ten (10) working days or return it to the billing provider."	REJECT: This section was deleted so the comment is no longer relevant.
225	Recommend phone validation or other method for paper claims. Suggest changing time for acknowledgment from 15 working days to 30 calendar days, the ERISA period for benefit determinations. Expand two-day requirement for acknowledgment of electronic claims to 15 days.	ACCEPT IN PART, REJECT IN PART: Revised regulations allow for phone validation, but declines to extend the time limit beyond 15 days for acknowledgment of paper claims or expand the 2-day requirement for acknowledgment of electronic claims.
226	Oversight of capitated providers is beyond Department's authority.	REJECT: The Department clearly has oversight authority over capitated provider through health plans. Section 1371, 1371.35, 1375.4 clearly require capitated providers to pay claims within the statutory time frames. In addition, the Department regulatory oversight of health plans it has the authority over health plans who contract with capitated providers to require the plan to include in their contract the requirement that the capitated providers accept and adjudicate claim



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		consistent with the Act and these regulations since these standards cannot be circumvented through the use of the delegated delivery model.
	1300.71(d)(1)	
227	Vigorously object to amendment shortening time period for physicians to file internal disputes with plan from 365 to 180 days. May take 180 days to determine that there is problem with claim.	ACCEPT: The revised regulations minimally provide providers 365 to file disputes.
228	Recommend that time frame for entering data from electronically transmitted claims be modified to 5 working days.	REJECT It is not prohibitively expensive to establish systems to acknowledge electronic claims simultaneously with their receipt. Therefore the two-day timeframe is adequate and appropriate
229	Recommend changing 180-day period to 365 days and clarifying that this is a minimum requirement. Add "except as required by any state or federal law or regulation."	ACCEPT: The time limit has been extended to 365 days),
230	With respect to the time period for submission of disputes, 180 days is insufficient considering limited resources. Request an extension of the time period from 180 days to 2 years.	ACCEPT IN PART: The time limit has been extended to 365days. However an extension to 2 years would be inconsistent with the purposes of sections 1371 and 1371.35
231	Recommend the time period for submission of disputes to be four years to be consistent with California contract law, which gives the ability to pursue payment inaccuracies for four years.	REJECT IN PART, ACCEPT IN PART: The Department rejects four years, but has amended the regulations to allow minimally one-year period for submitting disputes. Plans and providers and free to



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3rd Comment Period Ending: April 30, 2003

109	<p>Providers cannot be required to show "good cause" to obtain payment of late claims. The proposed regulations change the elements that are required to state a claim against a forfeiture (from "gross negligence" to "good cause"), and shift the burden of proof from the party enforcing the forfeiture (the plan) to the party defending against it (the provider).</p> <p>Recommend deleting requirement that providers show "good cause." The requirement is beyond the Department's statutory authority to overrule statutory and/or common law.</p>	<p>REJECT: The regulations establish the standards that the Department will use to determine if a payor is engaged in an unjust payment pattern. It is not intended to alter or change other common law remedies. To the extent that a claim is rejected within the standard set forth in these regulations the Department will not deem those activities to violate the claims settlement practices requirements of the Act. However, a provider is still free to pursue any other remedies available at law.</p>
1300.71(b)(5)		
110	<p>Delete provision that 365-day time limit shall not apply if overpayment was caused by provider fraud or misrepresentation.</p> <p>Will result in payers being free to seek alleged overpayment for an unlimited time period.</p>	<p>REJECT: To the extent that a provider is engaged in conduct that is either fraudulent or constitutes a misrepresentation, that provider is not entitled to the protection of sections 1371 or 1371.35.</p>
111	<p>Section 1300.71(b)(5), addressing the process for a plan or plan's capitated provider to request reimbursement for an overpaid claim, should be expanded to include any other agent of the plan or plan's capitated provider.</p>	<p>REJECT: To the extent that a plan or capitated provider utilizes an agent for ministerial services, those agents are limited by the criteria enumerated in section (b)(5). No further clarification is necessary.</p>
1300.71(c)		
112	<p>The leading section needs to be more clearly defined. Use</p>	<p>REJECT: The language of this section</p>

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	of words "Acknowledgement and Notification" could be interpreted as meaning that all plans must literally notify and acknowledge each claim by contacting the provider's office to inform them of receipt. If a plan provides a means whereby the provider can call to verify receipt or review a website, this should be sufficient.	allows a payor to establish a method of notification by which the provider may readily confirm the payor's receipt of the claim.
113	Appreciate changes in section, but suggest that word "identifying" be eliminated in first sentence. Unclear what is meant—acknowledgement is main goal of section.	REJECT: The use of the word "identify and acknowledge" each claim is necessary. Otherwise, a payor may acknowledge in general a claim, without specifically identifying the claim received. Providers often submit several claims to the same payor in the same day. In those situations, the payor must identify the specific claims received so that the provider can be assured that all claims submitted have been received.
114	The time period for acknowledging paper claims and provider disputes should be changed from 15 to 30 working days.	REJECT: 15 days is sufficient and a reasonable time period for acknowledging a paper claim. Delaying the acknowledgment to 30 days only serves to delay the reimbursement of clean claims.
115	If the plan has paid the claim within this 15-day time frame, then the plan should be relieved of the obligation to acknowledge receipt of the claim. Suggest adding the following language to the end of the paragraph: "unless the claim has been paid within this time frame."	REJECT: To the extent that a paper claim is paid in the 15-day timeframe, the actual payment will constitute acknowledgement of the claim. Therefore, additional language is not

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4th Comment Period Ending: May 27, 2003**

	1300.71(b)(5)	
41	Recommend deleting section in its entirety. Plans do not apply similar terms for hospitals to demand underpayment settlements if fraud or misrepresentation has occurred. The concern is the undefined misrepresentation or fraud. This clause will result in payers being free to seek revenue for alleged overpayments for an unlimited time period from providers.	REJECT. If a provider secures unwarranted reimbursement through misrepresentation or fraud that provider should not receive the protection of the Knox-Keen Act.
	1300.71(c)	
42	Commenter is concerned that it may be impossible to acknowledge a claim in some situations. For example, a claim with a missing ID cannot be entered. Claims belonging to other capitated groups cannot be entered, as that member will not be in the eligibility file, just as a plan would not be able to enter a claim for a member belonging to another plan. The industry method is to simply mail the claim back to the provider with a cover letter stating that the payer is unable to identify the member for which the claim is submitted.	REJECT: If a claim is received the payor can acknowledge that receipt so long as the claim includes the identification of the provider, if critical information necessary to adjudicate the claim is missing, the claim can be acknowledged and simultaneously denied as an incomplete claim. It is also anticipated that payors will adjust their processing system to comply with these regulations
	1300.71(c)(1)	
43	The timeframes are unnecessarily restricting. There may be times that system edits cause the electronic transmission of a claim to fail. Even in the most sophisticated organization, more than 2 working days may be necessary for these edits	REJECT: The regulation specifies sufficient and reasonable time periods for acknowledging claims. Delaying acknowledgement beyond the prescribed



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	to be researched, corrected, and reprocessed so that the claim can be entered.	time frame would only serve to delay the reimbursement of clean claims and continue the confusion that exists for providers concerning whether the payor has received the claims submission.
	1300.71(d)(4) and (5)	
44	Recommend changing 30 to 45 working days. Providers should receive same time period for dispute resolution research as health plans.	REJECT: The 30-day requirement for contesting a plan's request for reimbursement of an overpaid claim is specified in the Act.
	1300.71(d)(6)	
45	Commenter is concerned that providers may not reimburse or reply to notice. Without the ability to deduct from the providers, only recourse is court. For example, if wrong provider is paid inadvertently, it would be incumbent on the provider to return the incorrectly paid money or use the provider dispute resolution mechanism.	REJECT: Sections 1371 and 1371.35 require claims to be reimbursed, contested or denied within in a certain time period; the relevant sections do not authorize unilateral offsets. Payors are in exactly the same position as providers if they are engaged in a billing dispute that cannot be resolved - redress through the courts.
	1300.71(d)(6)(ii)	
45	Delete section entirely. State should not sanction health plan "clipping," "offsetting," or "take backs." Will only result in benefit to payers.	REJECT: To the extent that the parties agree to a process of reimbursement of overpayment of a claim, that process is not inconsistent with the requirements of the Act and is permissible.



1 because we have contracts with health plans now that are
2 in the 60 to 90 day category. So it's a little bit of a
3 problem for us, and certainly would mean that we would
4 have to make some audit changes there.

5 I think there's a way to do that where you could
6 have a lesser timeframe, and if there is good cause. And
7 you can set what the criteria is for good cause. Then
8 there would be reasonable times when maybe it is not
9 the -- I think I heard some comments today about "Well, we
10 didn't get information, we didn't have that information,"
11 and so they can't get the claim submitted. There are good
12 reasons. But to put it in there as no less than 150
13 really does kind of hurt us in the medical groups in
14 trying to do the IBNR's and the rest of the stuff that we
15 want -- that you want from us. So I'd ask you to consider
16 that.

17 The other one that came to us, from a fairly
18 large group, and that was the two working days for the
19 electronically acknowledgement of receipt of all claims.
20 Apparently it is difficult to upload that in some of the
21 systems. Now, maybe they're undergoing some revamp of
22 their system downstream some place, but right now they're
23 having some difficulty there. And they have asked to have
24 a longer period of time in there. If they can't be up
25 loaded quickly, it's generally due to either eligibility



1 problems or system configuration issues, either one. Two
2 days may -- we don't want to be out of compliance with
3 your regulations, so we're asking you to consider if you
4 can find a way to put some give in that.

5 The next issue -- and you've heard this one
6 before, so I'm going make it very quick. And that's on
7 the responsibility for the claims payment on a quarterly
8 basis. I frankly took this, until I got here today, as
9 really thinking what you really meant was we had to report
10 to the plans as we report to them all the time on what our
11 conscrement rate is. And we would certainly have
12 absolutely no trouble doing that. We do it anyway. But
13 we don't think you meant, unless I'm wrong here, that we
14 would have the health plans coming in to audit that every
15 quarter.

16 Now, if we were wrong in our interpretation, then
17 I would ask you to please don't do that; and to have us
18 continue to report.

19 Now, if these are made for people who don't do
20 the reporting that we do -- and that may be the case --
21 hopefully there can be some distinction there. We don't
22 want to be inundated -- in fact we're looking at ways to
23 streamline our own audit procedures in a couple of areas.
24 So to the extent that we all can streamline the processes,
25 that makes it better for our patients and, frankly, it



1 CALIFORNIA ASSOCIATION OF HEALTH PLANS

2 PROPOSED AMENDMENTS TO

3 TEXT OF PROPOSED REGULATIONS

4 CLAIMS SETTLEMENT PRACTICES AND

5 DISPUTE RESOLUTION MECHANISMS

6 1. Adopt Section 1300.71, California Code of Regulations (CCR) title 28, to read:

7 1300.71. Claims Settlement Practices

8 (a) Definitions.

9 (1) "Automatically" means the payment of the interest due to the provider within five

10 (5) working days of the payment of the claim without the need for any reminder or
11 request by the provider.

12 (2) "Complete claim" means a claim or portion thereof, if separable, including
13 attachments and supplemental information or documentation, which provides
14 "information necessary to determine payer/payer liability" and complies with one or
15 more of the following provisions:

16 (A) For emergency services and care provider claims as defined by Section
17 1371.35(j):

18 (i) the information specified in Health and Safety Code Section 1371.35(c); and

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

20 (B) For institutional providers:

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



1 ~~begin or be~~ limited to 60 days from date of payment or date of ~~notice-payment or denial~~
2 from the primary payor.

3 (4) A plan, ~~which that~~ denies a claim because it was filed beyond the claim filing
4 deadline, shall, upon provider's submission of a provider dispute pursuant to section
5 1300.71.38 within 90 days of the plan's denial and a showing of good cause by the
6 provider, accept, process, and, if otherwise appropriate, pay adjudicate the claim. "Good
7 cause" shall include only those circumstances outside the provider's control that may
8 occur in the responsible billing and processing of claims, such as the submission of the
9 claim to the wrong capitated provider or a protracted dispute between other parties over
10 the claim, and that precluded the timely filing of the claim.

11 (c) Time Period for Entering Claims. A plan shall enter into its system each claim
12 submission (whether or not complete, provided that the claim contains sufficient
13 information to enable the plan to enter the claim into the claim system), and shall identify
14 and acknowledge electronically the receipt of each claim or provide a means by which
15 each provider may readily confirm receipt of the claim electronically, by phone, website,
16 or another accessible mutually agreeable method of notification:

17 ~~(1) within two working days of the date of receipt of claims filed electronically with~~
18 ~~the office designated to receive claims, or⁶~~

19 ~~(2) In the case of a paper claim, that acknowledgement shall be provided within 15~~
20 working days of the date of receipt of the paper claims by the office designated to receive

⁶ If a claim is submitted electronically, the claimant will have a clear and precise electronic record of delivery. Except in the most unusual circumstances, the date of sending will also be the date of receipt. Thus, in almost all cases, it is unnecessary for the health plan to provide an acknowledgement of receipt. Mandating the requirement of such acknowledgement may add additional cost without a commensurate benefit.



1 claims. Acknowledgement by an electronic clearinghouse to which the provider has
2 submitted a claim shall constitute compliance with this section.

3 (d) Denying, Adjusting or Contesting a Claim. Requests for Medical Records A plan
4 shall not unreasonably deny, adjust, or contest a claim. For each claim that a plan denies,
5 adjusts or contests, the plan shall provide an accurate and clear explanation, subject to
6 any applicable federal or state rules regarding the format or content of such notice when
7 transmitted electronically, of the reasons for the action taken within the timeframes
8 specified in subsections (g) and (h). For each request for medical records made by a plan
9 for the purpose of processing a claim, the plan shall provide an accurate and clear
10 explanation of the necessity for the medical records requested by the plan. A plan shall
11 request medical records for the purpose of adjudicating a claim only when the
12 information is reasonably necessary for the plan to adjudicate the claim. In the event that
13 a plan includes with a request for medical records a statement explaining the necessity of
14 the medical records, and the plan subsequently denies the claim based on the provider's
15 failure to provide the requested medical records, any dispute arising from the denial of
16 such claim shall be handled as a provider dispute pursuant to Section 1300.71.38.

17
18 (e) Contracts for Claims Payment. A plan may contract for ministerial claims
19 processing services with a claims processing organization or ~~delegate claims payment~~
20 ~~responsibility to contract with~~ capitated providers who have an independent obligation to
21 pay claims, subject to the following conditions:

22 (1) the contract shall obligate the claims processing organization or the capitated provider
23 to process or pay claims for services provided to plan enrollees in accordance with the



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or who has delegated claims payment responsibilities to a capitated provider shall forward to the appropriate contracted claims processing organization or capitated provider such that it is received within five (5) two (2) working-days of the plan's receipt a claim incorrectly sent to the plan.

(3) If a plan is not the primary payor under coordination of benefits, the period for submitting supplemental or coordination of benefits claims to any secondary payors shall begin on the date of payment or date of notice from the primary payor.

(4) A plan, ~~which~~ that denies a claim because it was filed beyond the claim-filing deadline, shall, upon provider's submission of a provider dispute and a showing of good cause, accept, process, and, if otherwise appropriate, pay the claim.

(c) Time Period for Entering Claims. A plan shall enter into its system each claim submission (whether or not complete), and shall identify and acknowledge electronically the receipt of each claim and the recorded "date of receipt" as defined in 1300.71(a)(5), or provide a means by which each provider may readily confirm receipt of the claim and the recorded "date of receipt" as defined in 1300.71(a)(5), electronically, by phone, website, or another mutually agreeable method of notification:

7 The law defines date of receipt as the date received by the plan, and states the obligation shall not be waived with plans delegate claims payment responsibilities.

1300.71(1) only requires that contracting physicians be given directions for claim delivery. Non contracting physicians will be unfairly penalized when they are unable to identify the appropriate office to send claims. Plans should have the ability to immediately identify the appropriate claims processing organization or capitated provider and electronically transmit this information. In order for delegated providers to meet the timelines, plans must forward the claims to them with in 48 hours.

8 CMA offers this language as a practical solution to enable enforcement of the timely filing, timely payment provisions and interest requirements of the regulations. Moreover, the law requires that plans implement procedures that permit the determination of the date of receipt. (§1300.77). Given the complexity of multiple timelines imposed by provisions



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(1) within two working days of the date of receipt of claims filed electronically with the office designated to receive claims, or

(2) within 15 working days of the date of receipt of paper claims by the office designated to receive claims.

(d) Denying, Adjusting or Contesting a Claim. A plan shall not unreasonably improperly deny, adjust, or contest a claim. For each claim that a plan denies, adjusts or contests, the plan shall provide an accurate and clear explanation of the specific, legally justified reasons for the action taken within the timeframes specified in subsections (g) and (h).

(e) Contracts for Claims Payment. A plan may contract for ministerial claims processing services with a claims processing organization or delegate claims payment responsibility to capitated providers subject to the following conditions:

(1) the contract shall obligate the claim's processing organization or the capitated provider to process or pay claims for services provided to plan enrollees in accordance with the provisions of Health and Safety Code sections 1371, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38 and 1371.4, 1371.8 and 1375.4 and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4, and 1300.77.4 of title 28, and in accordance with all other Knox Keene requirements.

1300.71(a)5 ("Date of Receipt"), 1300.71(b)2, (Claims Filing Deadlines), and 1300.71(c) (Time period for Entering Claims), it will be essential to record this date and its inclusion will minimize disputes.

9 The term "unreasonably" suggests a higher threshold for denial, adjustment or contesting claims than is appropriate. Reasons for such actions must be specific and legally justified.

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HYDE, MILLER, OWEN & TROST

A PROFESSIONAL CORPORATION

ATTORNEYS AT LAW
428 J STREET, SUITE 400
SACRAMENTO, CALIFORNIA 95814

TELEPHONE (916) 447-7933
FACSIMILE (916) 447-5195
E-MAIL hmot@hmoat.com
www.hmoat.com

PAUL J. CHRISMAN
RICHARD H. HYDE
MATINA R. KONDOTRINIS
CHRISTIANE B. LAYTON
NANCY C. MILLER
WILLIAM L. OWEN
MATTHEW D. RUYAK
KIRK R. TROST

PHILIP L. ISENBERG
OF COUNSEL

November 18, 2002

Curtis Leavitt, Assistant Chief Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

**RE: Proposed Regulations
Claims Settlement Practices and Dispute Resolution
Comments on Second Period Text**

Dear Mr. *Leavitt* Leavitt:

On behalf of the California Association of Health Plans, we thank you for the opportunity to provide comment on the second period text of the regulations implementing AB 1455 (Scott) of 2000. This revised draft contains many of the significant improvements made during the informal comment period and addresses a significant number of concerns expressed by the Association and its members.

This draft of the regulations, however, contains some very significant departures from the prior version. These changes raise very serious concerns. This letter details those concerns and provides suggested changes in an attached a mock-up that address those concerns as well as provide technical recommendations for improved clarity. We believe that these issues warrant additional dialogue with the plans and other stakeholders to ensure that this regulatory framework is not overly burdensome.

In addition, several CAHP member plans will be submitted comments directly to the Department. We wish to go on record as supportive of those comments as well.

For your convenience, we have provided our comments on the language in the order in which they appear in the document. This order, however, does not reflect the importance of the items.

SECTION 1300.71 CLAIMS SETTLEMENT PRACTICES

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Subdivision (c): Time Period for Entering Claims

Subdivision (c) would require plans to enter claims into their systems provided a minimum amount of information, specified in detail in the proposed regulation, is included in the claim. The regulations would also require that claims be entered in a specific time period. We respectfully assert that the Department has no authority over the entering of claims into health plan or provider group systems. This ministerial, interim step in the claims-payment process is not addressed by the Act and thus beyond the Department's statutory obligations. Moreover, it is not necessary to regulate this aspect of the claims processing system in order to achieve the goals and standards of the statute.

Plans should be required to meet the statutory requirements to pay or deny claims within the statutorily required timeframes. Imposing this level of micromanagement on this process is unwise and creates unnecessary regulatory burdens and obligations for the Department. If the Department believes it is necessary for plans to establish some mechanism that will accurately track the date of receipt of claims for enforcement purposes and acknowledge claims received, then the Department should simply impose this requirement without setting forth voluminous details as to how this should be done.

In addition, the list of data elements contained in the regulation required for a claim to be entered is not sufficient to enter claims. In our previous letter, we requested additional items that are consistent with current systems. Most of those suggestions were incorporated. PacifiCare has requested additional items in its comment letter, and we support those additions. But we also requested language that would allow a plan to require, by contract, other data elements necessary to enter claims into the system as well as acknowledge federal regulations, which set forth specified fields that must be included with a complete claim. This language was not accepted. Without the ability to ensure certain data elements are present, plans will have significant implementation burdens.

More importantly, the Department should not be dictating the framework and configurations for data systems. The best solution to this issue is to delete the specific language regarding the entering of claims and retain the deadlines for acknowledgement and payment. We have made corresponding changes to the redline in this section as well as consistent changes in 1300.71.38.

Subdivision (c) (1), (2) and (3): Acknowledgement of Claims

Subdivision (c) requires that claims submitted in paper form be identified and acknowledged electronically. We do not believe that it is feasible for health plans to acknowledge in an electronic format claims submitted in a paper medium. If a provider is submitting a claim in paper form, he or she may not be able to receive an acknowledgement electronically. Claims forms (such as the UB 92 and CMS 1500) do not contain a field in which providers can insert an e-mail address or other method of electronic contact. Accordingly, we recommend that subdivision (c) (2) be revised to omit the word "electronically." If the Department desires that *electronic* claims be acknowledged electronically, this requirement should be moved to subsection (c)(1), such that it does not apply to paper claims. We have made this revision in the attached redline.

Subdivision (c) (2) would require plans to acknowledge the receipt of each claim through a means by which providers can confirm receipt—either electronically, by telephone, website or “*another mutually agreeable method.*” This language implies that each individual provider can unilaterally and for no reason reject electronic mail, telephone or website access and insist upon another means specific to that particular provider, which may not be economical. It also suggests that the plan must obtain the consent of each and every provider before establishing an alternative method.

While we appreciate the language that requires that this alternative be “mutually agreeable,” and also appreciate having language acknowledging other possible alternatives, given the possibility of future technological advances, we think that plans should be required to provide reasonable access, but not be required to provide provider-specific mechanisms subject to the consent of each and every provider, in the network or outside of the network. This is completely unworkable.

Subdivision (d) (6): Offsetting of Payments

Subdivision (d) (6) would prohibit a plan from offsetting payments when providers fail to reimburse the plan for overpayments within the specified timeframe unless the plan contract specifically authorizes this offset. This language exceeds the statutory authority granted to the Department in AB 1455. While we acknowledge the Department’s ability to establish fair procedures for the offsetting of uncollected overpayments consistent with the law, this language goes beyond that statute.

Section 1371.1, and to a lesser extent Sections 1371.347 and 1371.2, deal with overpayments. But those sections do not prohibit health plans from recovering monies owed to them through offsets, nor do the statutes require that plans include offset provisions in their contracts. If a provider refuses to refund an overpayment, plans have no other choice but to collect the overpayment by deducting the overpayment from future payments owed to the provider. Plans should be able to collect the overpayment through offsets if the provider fails to reimburse the plan within the time frame, **OR** if the provider’s contract authorizes these offsets. The language requires both conditions to be present, but such a requirement is inconsistent with statute.

In addition, this provision should apply only prospectively to contracts issued in the future, and should be modified to indicate the prospective application.

Subdivision (e) (2): Dispute Resolution

Paragraph (2) of this section would require plans to require their capitated providers to establish provider dispute resolution mechanisms. Plans should be able to elect to provide dispute resolution if they can and if they want to—for those claims and issues for which plans can intervene. In addition, any requirement by the plan that the provider establish such a mechanism should be limited to disputes relating to claims payment. The plan has no business dictating to a capitated provider whether and how to resolve other kinds of issues with contracting capitated providers, such as employee salaries, staffing levels, shareholder matters, bonuses, incentive payments and fees.

ATTACHMENT I

Below are comments that CAHP previously submitted that remain unaddressed. We would like to go on record as reiterating these concerns.

Subdivision (a) (1) (A) and (B): Interest Payments

The language of Paragraphs (A) and (B) of this subdivision requires a statement describing the method of calculating interest if the plan does not include the interest payment in the same envelope as the payment on the claim. There is no obligation under the statute to provide a description of the methodology, and no discernible public policy rationale for this requirement. Moreover, there is no understandable rationale for requiring the explanation only when the interest payment is in a different envelope. The statute requires that the interest be paid at the rate of 15 percent per annum (or 15 percent per year); plans must simply comply with this standard. We would appreciate some understanding as to why the Department feels this is necessary. We believe that it is unnecessarily burdensome.

Subdivision (c): Acknowledgement of Claims

This paragraph would require plans to acknowledge the receipt of each claim electronically, by telephone, website or "*another mutually agreeable accessible method.*" This language implies that each individual provider can unilaterally and for no reason reject electronic mail, telephone or website access and insist upon another means specific to that particular provider, which may not be economical. It also suggests that the plan must obtain the consent of each and every provider before establishing an alternative method.

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