DEPARTMENT OF Managed Health Care

Office of Financial Review
Division of Financial Oversight

Technical Assistance Guide

Claims Management and Processing

Issuance of this January 31, 2020 Technical Assistance Guide renders all other versions obsolete.

Foreword

The Knox-Keene Health Care Service Plan Act of 1975[1] (Knox-Keene Act), Section 1382, states that the director shall conduct an examination of the fiscal and administrative affairs of any health care service plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, as often as deemed necessary to protect the interest of subscribers or enrollees, but not less frequently than once every five years. The subject areas of the examination are to assess the overall fiscal soundness, financial viability and claims management of each plan, as well as to verify the plan's compliance with the Knox-Keene Act and related Rules.

This Technical Assistance Guide for Claims Management and Processing (Claims TAG) is a resource that may be used by health plans to assist with measuring the performance of their claims management function against relevant Knox-Keene Act requirements. The Department of Managed Health Care (Department or DMHC) institutes a risk-based approach that requires examiners to exercise their professional judgment to assess the risk inherent in a given plan's operation and determine the scope of the examination, while taking into consideration the many variables and uniqueness presented in each individual plan. Examiners review health plan responses and records to determine compliance with, at a minimum, the requirements contained herein. The Claims TAG is not intended to limit the scope of the examination or procedures performed by the DMHC.

This Claims TAG has been posted to the DMHC website to provide health plans information about the examination process for assessing a health plan's management of its claims. This document is a resource for the DMHC, external contractors and health plans, and should not be relied upon for any other purpose.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

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REQUIREMENT CM-001: CLAIMS MANAGEMENT STRUCTURE AND SYSTEMS

INDIVIDUAL(S)/POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described in this section, which may include:

- Key executives
- Board members
- Claims management and staff
- Finance management and staff
- Information Technology (IT) management and staff
- Customer Service management and staff
- Medical Director
- Utilization Management (UM) management and staff
- Provider Relations management and staff
- Internal Audit management and staff
- Training management and staff
- Compliance management and staff
- Provider Dispute Resolution (PDR) management and staff
- Contracts management and staff
- Contracted entity:
  - Claims management and staff
  - Principal Officer
  - Medical Director
  - IT management and staff
  - PDR management and staff

DOCUMENTS THAT MAY BE REVIEWED

- Organizational charts
- Meeting minutes
- Process flowcharts
- Training program information, such as staff training manuals/materials and schedule
- Customer service call reports/notes
- Information system(s) policies and procedures, including but not limited to data backup, system edits, payment rules and criteria, rate calculation, adjudication, privacy and security settings, data integrity measures, interfaces, system update process, schedule of updates, etc.
- Disaster recovery plan and results of most recent test
- Transaction system documentation, including but not limited to the data dictionary; interface with membership, practitioner and authorization data; system edits; software adjudications in place; etc.
- Contracts with delegated entities
- Quarterly Claims Payment Performance Reports
- Documentation of system updates
- Pre-delegation and delegation oversight audit methods and results
- Policies and procedures, claims samples, and other materials as deemed necessary from contracted entity performing claims processing function
- Other documents as deemed necessary

CM-001 – Key Element 1: Health Plan Resources and Oversight

The health plan has an adequate claims management structure that includes the appropriate level of management oversight, allocation of resources, interaction with key functional areas and staffing to ensure the timely and accurate payment of claims and PDRs.

Sections 1317, 1367, 1367.01, 1370, 1371, 1371.1, 1371.2, 1371.22, 1371.30, 1371.31, 1371.35, 1371.36, 1371.37, 1371.38, 1371.39, 1371.4, 1371.5, 1371.8, 1371.9 and 1375.1; and Rules 1300.67.3, 1300.71, 1300.71.31, 1300.71.38, 1300.71.39, 1300.71.4 and 1300.77.4 (and all Sections and Rules mentioned therein).

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
1.1.1	Does the health plan have sufficient resources to ensure the timely and accurate payment of claims and PDRs in accordance with the Knox-Keene Act?	*	*	*
1.1.2	In reference to 1.1.1, are resources sufficient to perform, at a minimum, the following activities:			
	a. Receiving claims properly?	*	*	*
	b. Appropriate tracking of claims and claim status, including claims under review for medical necessity?	*	*	*
	c. Processing claims payments timely and accurately?	*	*	*
	d. Retrieving claims rapidly?	*	*	*
	e. Routing and tracking pended claims to the appropriate departments?	*	*	*
	f. Contesting claims?	*	*	*
	g. Denying claims?	*	*	*
	h. Conducting internal claims, quality assurance and compliance audits?	*	*	*
	i. Performing appropriate system updates, assessments, backups and maintenance activities without interfering with the health plan's ability to process claims accurately and in a timely fashion?	*	*	*
	j. Providing sufficient support for existing hardware and software?	*	*	*
	k. Producing accurate, timely and relevant reports that allow management to review data and make decisions related to:			

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	• Claims processing (timeliness of payments, payment accuracy, claims status, inventory, backlog, deficiencies, trends, etc.)?	*	*	*
	• Statutory and regulatory compliance?	*	*	*
	• Audits?	*	*	*
	• Corrective action plans and implementation?	*	*	*
1.1.3	Is there a designated, fully licensed Medical Director or Clinical Director making all medical necessity determinations while meeting timely payment guidelines? [Section 1367.01(c)]	*	*	*
1.1.4	Do appropriate reporting relationships exist within the organization between key executive staff with ultimate accountability and responsibility for claims management functions (e.g., medical professionals are not involved in fiscal decisions)? [Section 1367(g)]	*	*	*
1.1.5	Is there appropriate management oversight and levels of review to enhance claims timeliness and accuracy?	*	*	*
1.1.6	Do sufficient internal controls exist to:			
	• Protect confidential information and data integrity?	*	*	*
	• Minimize the risk of fraudulent activity?	*	*	*
1.1.7	Is there documented evidence of timely and appropriate interaction with the following functional areas:			
	• Enrollee/member services?	*	*	*
	• Information Technology?	*	*	*
	• Utilization Management?	*	*	*
	• Medical Director/Clinical?	*	*	*
	• Provider Relations?	*	*	*
	• Finance?	*	*	*
1.1.8	Is there an established training program in place for claims, PDR and IT staff?	*	*	*
1.1.9	In reference to the above question, does the health plan's training program include orientation and training programs to ensure staff are properly trained and receive ongoing training in order to comply with statutorily mandated requirements, as well as industry and organizational needs?	*	*	*
1.1.10	Does the health plan have a contingency plan or sufficient backup resources to address staffing shortages due to illness, turnover or increased production needs?	*	*	*

CM-001 – Key Element 2: Information Systems

The health plan has adequate information systems in place to ensure the accurate and timely payment of claims.

Sections 1367, 1371, 1371.1, 1371.2, 1371.22, 1371.30, 1371.31, 1371.35, 1371.36, 1371.37, 1371.38, 1371.39, 1371.4, 1371.5, 1371.8, 1371.9 and 1375.4; and Rules 1300.71, 1300.71.31, 1300.71.38, 1300.71.39, 1300.71.4, 1300.75.4.5 and 1300.77.4 (and all Sections and Rules mentioned therein).

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No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
1.2.1	Does the health plan have an information system(s) that is able to sufficiently support claims operations and ensure the accurate and timely payment of claims in accordance with the Knox-Keene Act?	*	*	*
1.2.2	Is the health plan able to accept claims in electronic format or process from a paper submission, the data elements outlined in Rule 1300.71(a)(2), such as:			
	a. Complete UB 04 (CMS 1450) data set?	*	*	*
	b. Complete CMS 1500 (HCFA 1500) data set?	*	*	*
	c. Current, relevant terminology codes and modifiers?	*	*	*
	d. State-designated data requirements included in statutes or regulations?	*	*	*
1.2.3	Is the health plan's information system able to accurately calculate and apply contracted and non-contracted rates?	*	*	*
1.2.4	Pursuant to Rule 1300.71(a)(3)(B), does the health plan's information system calculate reasonable and customary rates based on statistically credible information that is updated at least annually and take the following into consideration:			
	a. Provider characteristics such as training, qualifications, time in practice, etc.?	*	*	*
	b. Nature of the services provided?	*	*	*
	c. Fees usually charged by the provider?	*	*	*
	d. Prevailing provider rates charged in the general geographic area in which the services are rendered?	*	*	*
	e. Other economic aspects or unusual circumstances?	*	*	*
1.2.5	Is the health plan's information system able to track and restrict edits and/or manual overrides to rates, coding and other data related to claims processing?	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
1.2.6	Does the health plan's information system interface with the following tables/schedules/files:			
	a. Member enrollment benefit tables?	*	*	*
	b. Practitioner/provider fee schedules?	*	*	*
	c. Authorization tables?	*	*	*
	d. Coding reference files?	*	*	*
	e. Ranges of reasonable and customary payments by geographic area?	*	*	*
1.2.7	Are all relevant tables/schedules/files updated timely?	*	*	*
1.2.8	Does the health plan's information system allow for the secure storage and timely retrieval of archived/filed records, including backup systems?	*	*	*
1.2.9	Does the health plan's information system have sufficient privacy, confidentiality, data integrity and security controls?	*	*	*

CM-001 – Key Element 3: Contracts for Claims Payment

If the health plan contracts with claims processing organizations, capitated provider groups, independent practice associations or other entities to pay claims, the health plan must have adequate oversight of the contracted organization and retains its obligations to meet statutory and regulatory requirements to timely and accurately process claims.

Sections 1363.5, 1367.01, 1371, 1371.1, 1371.2, 1371.22, 1371.31, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8; and Rules 1300.71, 1300.71.31, 1300.71.38, 1300.71.4 and 1300.77.4 (and all Sections and Rules referenced therein).

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No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
1.3.1	Does the health plan contract with claims processing organizations, capitated provider groups, or other entities to pay claims?	*	*	*
1.3.2	In reference to 1.3.1, does the health plan's contract(s) with these entities include provisions to ensure the following pursuant to Rule 1300.71(e) and Rule 1300.71(a)(8)(J):			

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	a. Acceptance and adjudication of claims in accordance with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, 1371.8, and Rules 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4? [Rule 1300.71(e)(1)]	*	*	*
	b. A fast, fair and cost effective provider dispute resolution mechanism as defined in Rule 1300.71.38 exists? [Rule 1300.71(e)(2)]	*	*	*
	c. Submission of Quarterly Claims Reports in accordance with Rule 1300.71(e)(3)? • Submitted to health plan within 30 days of the close of each calendar quarter. • Includes a tabulated record of each provider dispute received, categorized by date, and containing information identified in Rule 1300.71(e)(3)(ii). • Signed by and includes the written verification of a principal officer of the contracting entity stating that the report is true and correct to the best knowledge and belief of the principal officer.	*	*	*
	d. All records, notes and documents regarding its PDR mechanism and resolution of provider disputes are available to the health plan and Department? [Rule 1300.71(e)(4)]	*	*	*
	e. Providers that submit a claim dispute to the entity's PDR mechanism involving an issue of medical necessity or utilization review have an unconditional right of appeal for that claim dispute to the health plan's PDR mechanism for a de novo review and resolution for a period of 60 working days from the contracting entity's date of determination? [Rule 1300.71(e)(5)]	*	*	*
	f. The health plan has authorization to assume responsibility for the processing and timely reimbursement of provider claims in the event the contracting entity fails to timely and accurately reimburse its claims? [Rule 1300.71(e)(6)]	*	*	*
	g. The health plan has authorization to assume responsibility for the administration of the dispute resolution mechanism and the timely resolution of provider disputes in the event the contracting entity fails to timely resolve its provider disputes including issuance of a written decision? [Rule 1300.71(e)(7)]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	h. The health plan is not relieved of its obligations to comply with the Sections and Rules referenced in 1.3.2a? [Rule 1300.71(e)(8)]	*	*	*

End of Requirement CM-001: Claims Management Structure and Systems

REQUIREMENT CM-002: CLAIMS PROCESSING

INDIVIDUAL(S)/POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described in this section, for example:

- Claims management and staff
- Compliance management and staff
- Customer Service management and staff
- Contracts management and staff
- IT management and staff
- Medical Director
- UM management and staff
- Designated PDR Plan Officer
- PDR management and staff
- Provider Relations management and staff

DOCUMENTS THAT MAY BE REVIEWED

- Policies and procedures related to the processing of claims and PDRs, including but not limited to receipt, acknowledgement, approval, denial, appeal, contract oversight, provider disputes, emergency services, etc.
- Claims tracking forms
- Trend analyses
- Coding reference materials
- Claims and PDR reports
- Sample of claims selected using DMHC sampling methodology (e.g., paid, late, denied, high dollar and/or PDR), including but not limited to the associated claim history, remittance advice/explanation of benefits, check data, executed contract, fee schedule, correspondence to provider and/or enrollee, etc.
- Practitioner/provider template contract
- Paper claims submission forms
- Electronic submission protocol, including required format for transmission
- Example of electronic claim receipts and provider acknowledgements
- Printouts of claims system screens showing required data elements
- Evidence of acknowledgment of claims
- Backlog reports
- Claims production reports
- Complaint analyses
- Appeal analyses
- Provider dispute resolution analyses
- Denial notices
- Contracts with claims reviewers, including compensation terms
- Notice of dispute resolution mechanism
- Trending reports on disputes

- Other documents as deemed necessary

CM-002 – Key Element 1: Claims Processing Policies and Procedures

The health plan has well documented processes in place to support all key claims functions to ensure the timely and accurate processing of claims and PDRs.

Sections 1363.5, 1367, 1367.01, 1370, 1371, 1371.1, 1371.2, 1371.22, 1371.31, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, 1371.8, 1371.9 and 1375.1; and Rules 1300.67.3, 1300.71, 1300.71.31, 1300.71.38, 1300.71.4 and 1300.77.4 (and all Sections and Rules referenced therein).

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
2.1.1	Does the health plan have detailed policies and procedures in place to ensure compliance with statutorily mandated requirements and timeframes related to claims and PDRs?	*	*	*
2.1.2	In reference to the above question, does the health plan have policies and procedures to:			
	a. Ensure the timely and accurate acknowledgement, adjudication and payment of claims, including the proper application of payment rules and criteria? [Section 1371 et seq. and Rule 1300.71]	*	*	*
	b. Properly categorize and process claims by category, such as complete versus incomplete, those requiring special handling, etc.? [Rule 1300.71(a)(2)]	*	*	*
	c. Ensure the timely and accurate denial/contestation of claims, including notifications, requests for additional information and medical review? [Section 1371 et seq.]	*	*	*
	d. Ensure the proper submission, receipt, processing and resolution of contracted and non-contracted provider disputes? [Rule 1300.71.38]	*	*	*
	e. Ensure medical necessity determinations are reviewed by licensed staff, supported by clinical principles and processes, consistently applied and available to the public? [Section 1363.5 and Section 1367.01]	*	*	*
	f. Ensure the accurate payment of interest and penalty due? [Section 1371, Section 1371.35 and Rule 1300.71]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	g. Ensure requests for medical records are reasonably necessary to determine payer liability and contain reasonably relevant information in accordance with Rule 1300.71(a)(2), and the Rules and Sections incorporated therein.	*	*	*
	h. Ensure authorizations issued by delegated entities are forwarded to the health plan?	*	*	*

CM-002 – Key Element 2: Information for Contracting Providers

The health plan provides disclosures regarding claims submissions, dispute handling, fee schedules and other related information to contracted providers

Rules 1300.71, 1300.71.38 and 1300.75.4.1 (and all Sections and Rules referenced therein).

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
2.2.1	Has the health plan properly disclosed initially upon contracting, and upon the contracted provider's request, the following information in paper or electronic format pursuant to Rule 1300.71(l) and Rule 1300.71(a)(8)(M):			
	a. Directions (including the mailing address, e-mail address and fax number) for the electronic transmission, physical delivery and mailing of claims and/or provider disputes?	*	*	*
	b. A list of commonly required attachments, supplemental information and documentation consistent with Rule 1300.71(a)(10)?	*	*	*
	c. Instructions for confirming the health plan's or plan's capitated provider's receipt of claims and/or timeframe for the acknowledgement of provider disputes?	*	*	*
	d. The phone number(s) for claims and/or provider dispute inquiries and filing information?	*	*	*
	e. The identity of the office responsible for receiving and resolving provider disputes?	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	f. 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?	*	*	*
2.2.2	Does the health plan provide the following information to contracted providers initially upon contracting, annually and upon the provider's request pursuant to Rule 1300.71(o):			
	a. Complete fee schedule with the disclosure of any risk agreements as specified in Rule 1300.75.4.1(b)?	*	*	*
	b. Detailed payment policies and rules, and non-standard coding methodologies used to adjudicate claims? *(Policies, rules and methodologies used to adjudicate claims should be consistent with standards developed and/or used by nationally recognized medical societies and organization, federal regulatory bodies and major credentialing organizations.)* *(Policies, rules and methodologies used to adjudicate claims should include what is covered by any global payment provisions for all professional and institutional services*.)	*	*	*
2.2.3	Does the health plan provide a minimum of 45 days prior written notice before instituting any changes, amendments or modifications to the information provided to contracted providers as identified in Rule 1300.71(l) and Rule 1300.71(o)? [Rule 1300.71(m)]	*	*	*

CM-002 – Key Element 3: Claims Settlement Practices

The health plan's claims settlement practices comply with the requirements set forth in the Knox-Keene Act. This includes the accurate adjudication of contested and uncontested claims within the required timeframes, and the accurate reimbursement of interest and/or fees at the mandated rate for payments made beyond the mandated timeframes.

Sections 1367, 1367.01, 1370.2, 1371, 1371.31, 1371.35, 1371.36, 1371.4, 1371.5, 1371.8, 1399.55, 1399.56; and Rules 1300.71, 1300.71.31, 1300.71.38 and 1300.75.4.1 (and all Sections and Rules referenced therein).

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
2.3.1	Does the health plan accurately adjudicate and reimburse claims, including payment of interest and penalties, within the required timeframes?	*	*	*
2.3.2	Does the health plan's claims settlement practices encompass the following activities:			
	a. Appropriate receipt and acknowledgement of claims, including:			
	• Correctly recording the date of receipt as the working day when a claim, by physical or electronic means, is first delivered to the health plan's designated claims payment location, designated claims processor, or capitated provider? [Rule 1300.71(a)(6)]	*	*	*
	• Accurately acknowledging the receipt of claims in the same manner the claim was provided, or by another mutually agreeable accessible method, as follows: 1) electronic claims within two working days of the date of receipt, and 2) paper claims within 15 working days of receipt? [Rule 1300.71(c) and Rule 1300.71(a)(8)(E)]	*	*	*
	• Not imposing a claim receipt deadline that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service? [Rule 1300.71(b)(1) and Rule 1300.71(a)(8)(A)]	*	*	*
	• Not imposing a deadline for submitting supplemental or coordination of benefit claims that is less than 90 days from the date of payment or contest, denial, or notice from the primary payer to a secondary payer, if the plan or plan's capitated provider is not the primary payer under coordination of benefits? [Rule 1300.71(b)(1) and Rule 1300.71(a)(8)(A)]	*	*	*
	• Accepting and adjudicating late claims, when accompanied by a provider dispute and where the provider can demonstrate good cause for the delay, in accordance with Section 1371 or Section 1371.35 and applicable regulations? [Rule 1300.71(a)(8)(C)]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	b. Timely adjudication of claims, including:			
	• Reimbursing a complete claim, or portion thereof, that is not contested or denied within 30 working days after the date of receipt for specialized plans and 45 working days for full service health plans? [Section 1371(a)(1), Rule 1300.71(a)(8)(K) and Rule 1300.71(g)]	*	*	*
	• Reimbursing a complete claim, or portion thereof, that is not contested or denied within 30 working days after the date of receipt for specialized health plans, and PPO and POS lines of business maintained by full service health plans? [Section 1371(a)(1), Rule 1300.71(a)(8)(K), Rule 1300.71(g)(1) and Rule 1300.71(g)(2)]	*	*	*
	c. Accurate reimbursement of claims, including:			
	• Reimbursing claims in accordance with Section 1371 or Section 1371.35? [Rule 1300.71(a)(8)(K)]	*	*	*
	• Reimbursing non-contracting individual health professionals providing covered non-emergency services in a contracting facility the greater of 125 percent of Medicare or the health plan's average contracted rate? [Section 1371.31(a)(1), Rule 1300.71.31 and Rule 1300.71(a)(8)(U)]	*	*	*
	• Reimbursing providers for emergency services and care provided to enrollees until the care results in stabilization of the enrollee? [Section 1371.4(b)]	*	*	*
	• Paying for ambulance or ambulance transport services for an enrollee as a result of a "911" emergency response system request if the request was made for an emergency medical condition and the enrollee reasonably believed ambulance transport was required? [Section 1371.5(a)]	*	*	*
	d. Accurate reimbursement of interest and penalty, including:			
	• For non-emergency claims, automatically including interest at the rate of 15 percent per annum beginning the first calendar day after the 30- or 45-working day period? [Section 1371(a)(2), Rule 1300.71(a)(8)(K) and Rule 1300.71(i)(2)]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	• For emergency claims, automatically including interest that is the greater of $15 for each 12-month period or portion thereof (non-prorated), or interest at the rate of 15 percent per annum beginning the first calendar day after the 30- or 45-working day period? [Section 1371.35(b), Rule 1300.71(i)(1) and Rule 1300.71(a)(8)(K)]	*	*	*
	• Automatically *("automatically" is defined as within five working days of the payment of the claim)* including accrued interest in the payment of a claim; the claimant is not required to submit a request for interest? [Section 1371(a)(2) and Rule 1300.71(a)(1)]	*	*	*
	• Paying a $10 fee to the claimant when failing to comply with the interest requirement? [Section 1371(a)(2) and Rule 1300.71(j)]	*	*	*
	e. Appropriate treatment of authorizations, including:			
	• Not rescinding or modifying an authorization after the provider renders the health care service in good faith pursuant to the authorization? [Section 1371.8 and Rule 1300.71(a)(8)(T)]	*	*	*
	• Not requiring prior authorization for the provision of emergency services or care necessary to stabilize an enrollee's medical condition? [Section 1371.4(b)]	*	*	*
	• Proceeding with one of the following steps if disagreements regarding the need for necessary medical care following stabilization of the enrollee occur? [Section 1371.4(d)] - Have contracting medical personnel take over the care of patient; OR - Transfer the patient to another contracting general acute care hospital; OR - If the plan fails to satisfy these requirements, further necessary care will be deemed authorized by the plan and payment for this care may not be denied.	*	*	*
	• Ensuring that only appropriate licensed health care professionals who are competent to evaluate the specific clinical issues involved deny or modify requests for authorizations for reasons of medical necessity? [Section 1367.01(e)]	*	*	*
	f. Timely and appropriate contestation or denial, including:			

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	• Notifying the claimant in writing if a claim, or portion thereof, is denied or contested, within 30 working days (specialized health plans and POS lines of business) or 45 working days (full service health plans) of receipt of claim? [Section 1371.35 and Rule 1300.71(h)]	*	*	*
	• Informing the provider of the availability of the provider dispute resolution mechanism and procedures for obtaining forms and instructions? [Rule 1300.71.38(b) and Rule 1300.71(a)(8)(P)]	*	*	*
	• Providing providers with an accurate and clear explanation of the specific reasons for denying, adjusting or contesting a claim? [Rule 1300.71(a)(8)(F) and Rule 1300.71(d)(1)]	*	*	*
	• Disclosing to a provider or patient, upon their demand, the specific rationale used in determining why a claim was rejected? [Section 1399.55]	*	*	*
	• Communicating decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrently with the provision of health care services to enrollees in writing? [Section 1367.01(h)(4)]	*	*	*
	• Completing reconsideration of claims contested for not enough information reasonably necessary to determine payer liability within 30 working days for specialized health plans, or 45 working days for full service health plans, after receipt of the necessary information? [Section 1371(a)(4), Section 1371.35(e), Rule 1300.71(a)(2) and Rule 1300.71(h)(3)]	*	*	*
	• Not denying a claim for health care services provided in a licensed acute care hospital due to the lack of prior authorization if services were related to services previously authorized and if all of the following conditions are met? - Services were medically necessary at the time. - Services provided after the health plan's normal business hours. - Health plan does not have a system that allows for responding to authorization requests within 30 minutes of the time the request was made. [Section 1371.36(a)]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	• Not compensating entities retained by a health plan to review claims based on: 1) a percentage of the amount by which a claim is reduced for payment, or 2) the number of claims or the cost of services for which the person has denied authorization or payment? [Section 1399.56] *Section 1399.57 exempts Medi-Cal from Section 1399.56.*	*	*	*
	g. Appropriate processing of misdirected claims, including:			
	• Forwarding misdirected claims involving emergency service and care to the appropriate capitated provider within 10 working days? [Rule 1300.71(a)(8)(B) and Rule 1300.71(b)(2)(A)]	*	*	*
	• For claims that do not involve emergency services or care, if the provider is contracted with the plan's capitated provider, within 10 working days of receipt the plan either: 1) sends the claimant a notice of denial with instructions to bill the capitated provider, or, 2) forwards the claim to the appropriate capitated provider? [Rule 1300.71(a)(8)(B) and Rule 1300.71(b)(2)(B)]	*	*	*
	• For claims that do not involve emergency service or care, if the provider is *not* contracted with the plan's capitated provider, forwarding claims within 10 working days of receipt to the appropriate capitated provider? [Rule 1300.71(a)(8)(B) and Rule 1300.71(b)(2)(B)]	*	*	*
	• Ensuring capitated providers forward claims for which the health plan is responsible for adjudicating within 10 working days of receipt? [Rule 1300.71(a)(8)(B) and Rule 1300.71(b)(3)]	*	*	*
	h. Appropriate notice of overpayment, including:			
	• Submitting requests for reimbursement via written notice of overpayment to provider within 365 days of date of payment? [Rule 1300.71(a)(8)(D) and Rule 1300.71(b)(5)]	*	*	*
	• Processing contested notices of overpayment of claims as provider disputes pursuant to Rule 1300.71.38? [Rule 1300.71(a)(8)(D) and Rule 1300.71(d)(4)]	*	*	*
	i. Appropriate request of medical records, including:			

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	• Not including contract provisions in provider contracts requiring the provider to submit medical records that are not reasonably relevant for the adjudication of claims? [Rule 1300.71(a)(8)(G)]	*	*	*
	• Requesting medical records less frequently than in three percent of claims submitted for non-emergent authorized claims over any 12-month period (unless there are reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices)? [Rule 1300.71(a)(8)(H)]	*	*	*
	• Requesting medical records less frequently than in 20 percent of claims for emergency services and care over any 12-month period (unless there are reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices)? [Rule 1300.71(a)(8)(I)]	*	*	*
	j. Requiring or allowing a provider to waive any right conferred upon the provider or any obligation imposed upon the health plan by the Rules and Sections stated in Rule 1300.71(p). [Rule 1300.71(a)(8)(O)]	*	*	*
	k. Determining the average contracted rate for health care services subject to Section 1371.9, in a manner consistent with Rule 1300.71.31? [Rule 1300.71(a)(8)(V)]	*	*	*

CM-002 – Key Element 4: Provider Dispute Resolution Mechanism(s)

The health plan has adequate mechanisms in place to facilitate the resolution of claims issues/disputes from providers.

Rule 1300.71.38 and all Sections and Rules referenced therein.

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
2.4.1	Does the health plan have a fair, fast and cost effective dispute resolution mechanism(s) in place for both contracting and non-contracting providers? [Rule 1300.71.38]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
2.4.2	Does the health plan notify providers of the availability of the PDR mechanism whenever a claim is denied or adjusted? [Rule 1300.71.38(b)]	*	*	*
2.4.3	Does the notice to providers contain procedures for obtaining the forms, instructions for filing a dispute and the appropriate mailing address? [Rule 1300.71.38(c)(2)-(3)]	*	*	*
2.4.4	Does the health plan's PDR mechanism entail the requirements outlined in Rule 1300.71.38, including:			
	a. A designated principal officer to be primarily responsible for the maintenance of the health plan's provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care? [Rule 1300.71.38(h)]	*	*	*
	b. Appropriate acknowledgement of disputes, including:			
	• Acknowledging disputes within two working days of receipt if filed electronically and 15 working days of receipt if filed by paper? [Rule 1300.71.38(e)]	*	*	*
	• Referencing the same number assigned to the original claim? [Rule 1300.71.38(c)(1)]	*	*	*
	c. Timely processing and resolution of disputes, including:			
	• Resolving and issuing a written determination letter within 45 working days after the receipt of the original or amended dispute? [Rule 1300.71.38(f)]	*	*	*
	• Returning provider disputes lacking information identified in Rule 1300.71.38(a)(1) for contracting providers and Rule 1300.71.38(a)(2) for non-contracting providers?	*	*	*
	• Not requesting providers to resubmit previously submitted documentation unless the documentation was returned to the provider. [Rule 1300.71.38(d)(2)]	*	*	*
	• Setting deadlines for submission of provider disputes that are not earlier than 365 days after the health plan's action, or, if no action is taken by the health plan, 365 days after the time for contesting or denying a claim has expired? [Rule 1300.71.38(d)(1)]	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
	• Ensuring an appropriately licensed health care provider or medical director reviews the appeal of a claim contested based on clinical issues, and the designated reviewer is determined to be competent to evaluate the specific clinical issues presented in the appealed claim? [Section 1370.2]	*	*	*
	d. Ability to track and trend the submission of provider disputes and their resolution to identify areas of improvement, implement corrective actions, and improve organizational processes and systems?	*	*	*
2.4.5	Is the health plan able to compile the data required to complete the "Annual Plan Claims Payment and Dispute Resolution Mechanism Report" and submit to the Department no more than 15 days after the close of the calendar year? [Rule 1300.71.38(k)] The "Annual Plan Claims Payment and Dispute Resolution Mechanism Report" is to include: • The number and types of providers submitting disputes. • A summary of the disposition of all provider disputes, including a description of the types, terms and resolution. (Bundled submissions must be reported separately as individual disputes.) • A detailed statement disclosing emerging or established patterns of provider disputes and how the information has been used to make improvements and develop corrective action plans.	*	*	*
2.4.6	Does the health plan receive and process non-contracted provider disputes related to the health plan's computation of reasonable and customary, determined in accordance with Rule 1300.71(a)(3)(B), as a provider dispute in accordance with Rule 1300.71.38? [Rule 1300.71(g)(3)]	*	*	*

End of Requirement CM-002: Claims Processing

REQUIREMENT CM-003: QUALITY ASSURANCE

INDIVIDUAL(S)/POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Audit management and staff
- Quality Assurance management and staff
- Claims management and staff
- Customer Service management and staff
- IT management and staff

DOCUMENTS THAT MAY BE REVIEWED

- Policies and procedures for internal audits and quality assurance activities
- Performance standard methodology
- Internal audit methodology (frequency, selection of claims, elements audited, etc.)
- Internal audit reports
- Trend analyses
- Corrective actions and quality improvement activities implemented as a result of analyses
- Other documents as deemed necessary

CM-003 – Key Element 1: Performance Standards

The health plan has established performance standards to measure the plan's accuracy and timeliness of payments in a manner consistent with mandated requirements.

Rule 1300.71 and all Sections and Rules referenced therein.

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
3.1.1	Does the health plan have established performance standards to ensure compliance with the mandated claims settlement requirements identified in Rule 1300.71(a)(8)?	*	*	*
3.1.2	Does the health plan have written policies and procedures outlining the performance standards referenced in 3.1.1?	*	*	*

CM-003 – Key Element 2: Quality Assurance and Oversight Audits

The health plan conducts regular oversight and quality assurance audits to ensure the accurate and timely payment of claims, including the evaluation of established performance and quality standards.

Sections 1370 and 1371, Rule 1300.71, and all Sections and Rules referenced therein.

Go to Statutory/Regulatory Citations

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
3.2.1	Does the health plan conduct, either internally or externally, oversight and quality assurance audits related to claims, including the measurement of performance against key standards, to identify areas of concern, systemic issues, etc.?	*	*	*
3.2.2	Are the health plan's audit and compliance processes assessed and updated periodically?	*	*	*
3.2.3	Do the audits take into consideration the following:			
	a. Complaints and appeals?	*	*	*
	b. Trends?	*	*	*
	c. Performance measures?	*	*	*
	d. Procedural error rates, including but not limited to:	*	*	*
	• Matching claims to authorization?			
	• Timeliness of payment?	*	*	*
	• Benefits application?	*	*	*
	• Appropriate application/interpretation of contracts?	*	*	*
	e. Financial error rates, including but not limited to:			
	• Under or overpayment?	*	*	*
	• Fraud?	*	*	*
	f. Customer service issues?	*	*	*
	g. Provider dispute resolutions?	*	*	*
	h. Compliance with statutory and regulatory requirements?			
3.2.4	Are corrective actions implemented to timely address the issues identified as a result of the audits?	*	*	*
3.2.5	Are the results of the audits and corrective actions communicated to the appropriate contracting claims processing organizations, employees and management?	*	*	*
3.2.6	Are post-implementation activities conducted to ensure corrective actions were properly implemented and identified issues resolved?	*	*	*

No.	**Assessment Question** (cells containing an * are placeholders for an answer to the question)	**Yes**	**No**	**N/A**
3.2.7	Does the health plan disclose to the Department within 60 days of the close of each calendar quarter, in a single combined document pursuant to Rule 1300.71(q)(1): • Emerging patterns of claims payment deficiencies. • Whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95 percent of its claims, including the payment of interest and penalties, as identified in the Act. • Corrective actions taken over the preceding two quarters.	*	*	*
3.2.8	Does the health plan submit to the Department, within 15 days of the close of each calendar year, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report, information disclosing the claims payment compliance status with the Knox-Keene Act of the health plan and each of its claim processing organizations and capitated providers? [Rule 1300.71(q)(2)]	*	*	*

End of Requirement CM-003: Quality Assurance

GLOSSARY OF TERMS

TERM	DEFINITION
Adjudication	Processing a claim through a series of edits in order to determine proper payment.
Allowable Charge	The maximum fee that a third party will reimburse a provider for a given service. An allowable charge may not be the same amount as either a reasonable or customary charge.
Allowable Costs	Charges for services rendered or supplies furnished by a health provider which qualify for an insurance reimbursement.
Appeal	A formal request by a provider or enrollee for reconsideration of a decision to deny, modify or delay health care services, with the goal of finding a mutually acceptable solution. This may include utilization review recommendations, benefit determinations, administrative services regarding quality of care or quality of service issues. (See Grievance)
Benefit	A service provided under an insurance policy or prepayment plan.
Bill Review	Third-party review of medical bills for excessive or inappropriate charges. Some workers compensation state statutes mandate payers to examine bills.
Billed Claims	The fees or costs for healthcare services provided to a covered person, submitted by a healthcare provider.
Capitation	In the strictest sense, a stipulated dollar amount established to cover the cost of healthcare delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a healthcare provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Claim	Information, submitted by a provider or a covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made. The term generally refers to the liability for healthcare services received by covered persons. A claim can be clean or non-clean. A clean claim is a complete claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant

TERM	DEFINITION
	information and information necessary to determine payer liability.
Claims Administration	A carrier function involving the review of health insurance claims submitted for payment, by individual claim or in the aggregate. Claims administration, as it relates to professional review programs, is an identification procedure, screening treatment or charge pattern, for subsequent peer review and adjudication.
Claims Review	The method by which an enrollee's healthcare service claims is reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.
Clinical Guidelines	Systematically developed descriptive tools or standardized specifications for care to assist practitioners in treatment decisions about appropriate health care for specific clinical circumstances. Clinical guidelines are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus. Clinical guidelines may be called practice parameters, treatment protocols, clinical criteria, or practice guidelines.
CMS 1500 (formerly known as HCFA 1500)	A universal form, developed by the government agency known as Center for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), for providers of services to bill professional fees to health carriers. HCFA 1500 forms may also be used. The only difference between the CMS 1500 form and the HCFA 1500 form is the name of the form; everything else remains the same.
Coding System	ICD-9 System- a diagnoses and procedure coding system for hospital care; CPT-4 System- used to identify physician services like injections and surgeries; NDC Coding System - a system used by insurers to pay outpatient pharmaceutical claims; HCPCS System- a Medicare system for identifying a wide variety of services including injectable drugs used in physicians' offices.
Coinsurance	The portion of covered health costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.
Complaint	An oral or written expression of dissatisfaction by a member.
Concurrent Review	An assessment that determines medical necessity or appropriateness of services as they are being rendered,

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	such as an assessment of the need for continued impatient care for hospitalized patients.
Copay/Copayment	A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the service is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayment are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered.
Coverage	Entire range of protection provided under an insurance contract.
Coverage Decision	The approval or denial of health care services by a health plan, or one of its delegated entities based upon the benefits specified in the enrollee's contract with the health plan.
Covered Expenses	Medical and related costs, experienced by those covered under the policy, that qualify for reimbursement under terms of the insurance contract.
Criteria	Systematically developed objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes. Criteria are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus.
Customary, Prevailing, and Reasonable Charges	Method of reimbursement used under Medicare, which limits payment to the lowest of the following: physician's actual charge, physician's median charge in a recent prior period (customary), or the 75th percentile of charges in the same time period (prevailing). See definitions of UCR & Reasonable and Customary in Glossary of Terms
Date of Service	The date on which healthcare services were provided to the covered person.
Deductible	The amount of eligible expense a covered person must pay each year from his/her own pocket before the health plan will make payment for eligible benefits.
Delegation	A formal process by which a health plan gives another entity the authority to perform certain functions on its behalf, such as claims processing, credentialing, and utilization management. The plan maintains the responsibility for ensuring that the function is performed correctly.

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Denial	Non-approval of a requested care or service. This includes any partial approvals and denials, modifications, or delays to the original request.
Disallowance	A denial by the payer for portions of the claimed amount. Examples of possible disallows include coordination of benefits, not-covered benefits, or amounts over the maximum fee.
Duplicate Coverage Inquiry (DCI)	A request to an insurance company or health plan by another insurance company or health plan to find out whether coverage exists for the purpose of coordination of benefits.
Eligible Expenses	The lower of the reasonable and customary charges or the agreed upon fee for health care services and supplies covered under a health plan.
Emergency Medical Condition [Section 1317.1(b)]	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.
Emergency Services and Care [Section 1317.1(a)(1)]	Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
Encounter	Any measurable utilization of service by an enrollee.
Evidence of Coverage (EOC)	A description of the benefits included in a carrier's plan. The evidence of coverage is required by state laws and represents the coverage provided under the contract issued to the employer. The EOC is provided to the enrollee in the form of a certificate, agreement, contract, brochure, or letter of entitlement.
Explanation of Benefits (EOB)	The statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.
Exclusions	Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.

TERM	DEFINITION
Expected Claims	The projected claim level of a covered person or group for a defined contract period. This level also becomes known as a desired loss ratio or break-even point in relationship to projected premium.
Experimental Therapy	Any treatment, device, or procedure that is not currently approved as an accepted standard of practice, but is subject to rigorous ethical and scientific investigative methods in a controlled setting. (See Investigational Therapy)
FFS	Fee-For-Service
Fee Schedule	A schedule of services with pre-established payment amounts that could be expressed as a percentage of billed charges, a percentage of Medicare RBRVS, flat rates, maximum allowable amounts, or other equivalent payment arrangement.
Fiscal Intermediary	The agent that has contracted with providers of service to process claims for reimbursement under healthcare coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making adult of providers' records.
Grievance	Any request by an enrollee for a plan to address a perceived problem. NCQA classifies all such requests as stages in the appeals process. The State of California classifies all complaints and appeals as grievances.
Health Maintenance Organization (HMO)	A full service health plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3)
Healthcare Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS includes Current Procedural Terminology (CPT) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) in order to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national, those beginning with W through Z are local.
In-Area Services	Healthcare received within the authorized service area from a participating provider of the health plan.
Incurred But Not Reported (IBNR)	Refers to a financial accounting of all services that have been performed, but have not been invoiced or recorded, or

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	estimates of costs for medical services provided for which a claim has not yet been filed. This is a crucial concept for proactive providers who are beginning to explore arrangements that put them in the role of adjudicating claims. Failure to account for these potential claims could lead to misinformed decisions. Good administrative operations have fairly sophisticated mathematical models to estimate this amount at any given time.
Incurred Claims	All claims with dates of service within a specified period.
Independent Medical Review (IMR)	The review of a disputed health care service by an unbiased clinically and financially separate expert or panel of experts.
Independent Practice Association (IPA) model	A plan that contracts directly with physicians in independent association (IPA) model practices; and/or contracts with one or more multi-specialty group practices the plan may be predominantly organized around solo/single specialty practices.
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	This is the universal coding method used to document the incidence of disease, injury, mortality and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. The ICD-9-CM was issued in 1979. This system is used to group patients into DRGs, prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.
Investigational Therapy	Any treatment, device, or procedure that is not currently approved as an accepted standard practice, but is subject to rigorous ethical and scientific investigative methods in a controlled setting. (See Experimental Therapy)
Life Threatening	Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted or disease or conditions with potential fatal outcomes, where the end point of clinical interventions is survival.
Maximum Allowable Cost (MAC) List	Specified multi-source prescription medications that will be covered at a generic product cost level established by the plan. This list, distributed to participating pharmacies, is subject to periodic review and modification by the plan. The MAC list may require covered persons to pay a cost differential for a brand name product.
Maximum Allowable Fee Schedule	A healthcare payment system which reimburses up to a specified dollar amount for services rendered.
Medical Necessity	The determination that an intervention recommended by a treating practitioner is: (1) the most appropriate available

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	supply or level of service for the individual in question, considering potential benefits and harms to the individual, and (2) known to be effective in improving health outcomes. For interventions not yet in widespread use, a plan determines effectiveness, based on the best available scientific evidence. For established interventions, a plan determines effectiveness based on scientific evidence, professional standards and expert opinion.
Monitor	A periodic or ongoing performance measurement to determine opportunities for improvement or the effectiveness of interventions.
National Drug Code (NDC)	Classification system for drug identification.
Non-formulary Prescription Drugs	A drug listed on the formulary.
Paid Claims	The amounts paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any covered person liability for ineligible charges or for deductibles or copayments. If the carrier has preferred payment contracts with providers (e.g., fee schedules or capitation arrangements), lower paid claims liability will usually result.
Payer	A public or private organization that pays for or underwrites coverage for healthcare expenses.
Peer Review	Evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician).
Physician's Current Procedural Terminology (CPT)	List of services and procedures performed by providers, with each service/procedure having a unique 5-digit identifying code. CPT is the health care industry's standard for reporting of physician services and procedures. Used in billing and records.
Practitioner	A licensed professional who provides health care services.
Primary Care Physician	A physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialty care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.
Primary Care Provider	Any provider who defines their scope of services to be that of a primary care physician. (See "Primary Care Physician")

TERM	DEFINITION
Prior Review/Authorization	A formal process requiring a provider to obtain approval to provide particular services or procedures before they are rendered. This is usually required for nonemergency services that are expensive or likely to be abused or overused. A managed care organization will identify the services and procedures that require prior authorization, without which the provider may not be compensated.
Protocol	A written plan specifying the procedures to be followed when performing a particular examination, conducting research or providing care for a particular condition. (See Clinical Guidelines in Glossary of Terms)
Provider	Usually refers to a hospital or doctor who "provides" care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called payers. The lines are blurred sometimes, however, when providers create or manage health plans. At that point, a provider is also a payer. A payer can be provider if the payer owns or manages providers, as with some staff model HMOs.
Provider Group	A medical group, independent practice association, or any other similar group of providers.
Prudent Layperson Rule	A standard where the judgment of a medically untrained individual is used as the basis for the urgency or emergent nature of any condition.
Quality Improvement (QI)	Also called performance improvement (PI). This is the more commonly used term in healthcare, replacing QA. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs usually use tools such as cross functional teams, task forces, statistical studies, flow charts, process charts, etc.
Quality Management (QM)	A formal set of activities designed to review and to safeguard the quality of care and services provided to enrollees. The effort to assess and improve the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care and services are provided. QM includes quality assessment and implementation of corrective actions to address any deficiencies identified in the quality of care and services provided to individuals or populations, as well as re-assessment to determine the impact, if any, of corrective actions on the identified deficiencies.
Reasonable and Customary	Commonly charged fees for health services in a certain area. The use of fee screens to determine the lowest value

TERM	DEFINITION
	of provider reimbursement based on: (1) the provider's usual charge for a given procedure, (2) the amount customarily charged for the service by other providers in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates. See Customary, Prevailing and Reasonable Charges definition on pg. B-2.
Retrospective Review	Assessment of the appropriateness of medical services on a case-by-case or aggregate basis after the services have been provided.
Standards	Authoritative statements of: (1) minimum levels of acceptable performance or results, (2) excellent levels of performance or results, or (3) the range of acceptable performance or results.
Stop-loss Insurance	Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. Reinsurance purchased to protect against the single overly large claim or the excessively high aggregated claim during a set period. Also see Reinsurance and Specific Stop Loss.
Turnaround Time (TAT)	The measure of a process cycle from the date a transaction is received to the date completed. (For claims processing, the number of calendar days from the date a claim is received to the date payment is in the mail.)
Unbundling	The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.
Uniform Billing Code of 1992 (UB-92)	Bill form used to submit hospital insurance claims for payment by third parties. Similar to CMS 1500, but reserved for the inpatient component of health services.
Usual, customary and reasonable (UCR)	Commonly charged fees for health services in a certain area. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates. See Customary, Prevailing and Reasonable Charges and Reasonable and Customary definitions in Glossary of Terms.
Utilization Management (UM)	The system of evaluating the necessity, appropriateness and efficiency of health care services. Includes determining the coverage for medical care services as well as providing any needed assistance to clinician or patient in cooperation with other parties, to ensure appropriate use of resources. In

TERM	DEFINITION
	some plans, discharge planning and case management are part of the UM system.
Utilization review	A formal review of the utilization and coverage of health care services, which can be performed on a prospective (prior authorization), concurrent, and retrospective basis.

GLOSSARY OF STATUTORY AND REGULATORY CITATIONS

Statutory or Regulatory Citation	Description
Section 1317	(a) Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.
Section 1317.1(a)(1)	"Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
Section 1317.1(b)	"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.
Section 1363.5	(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01. (b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or

Statutory or Regulatory Citation	Description
	utilization management functions, to determine whether to authorize, modify, or deny health care services shall: (1) Be developed with involvement from actively practicing health care providers. (2) Be consistent with sound clinical principles and processes. (3) Be evaluated, and updated if necessary, at least annually. (4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case. (5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this para-graph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means. (c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: “The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.”
Section 1367(g)	The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.
Section 1367(h)	(1) Contracts with subscribers and enrollees, including group con-tracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted. (2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes. (3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute

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	resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.
Section 1367(j)	A health care service plan shall not require registration under the federal Controlled Substances Act (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code. Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services. The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services. The obligation of the plan to comply with this chapter shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.
Section 1367.01	(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section. (b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

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	(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section. (d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h). (e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h). (f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5. (g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination. (h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements: (1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the

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	requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000. (2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management. (3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed

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	upon by the treating provider that is appropriate for the medical needs of that patient. (4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations. (5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the

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	provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies. (6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. (i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services. (j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance. (k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section. (l) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270. (m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the

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	Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.
Section 1367.02(c)-(d)	(c) Each plan that uses economic profiling shall, upon request, provide a copy of economic profiling information related to an individual provider, contracting medical group, or individual practice association to the profiled individual, group, or association. In addition, each plan shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles of individual providers shall, upon request, provide a copy of individual economic profiling information to the individual providers who are profiled. The economic profiling information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the plan and the individual provider, medical group, or individual practice association terminates, or until 60 days after the date the contract between the medical group or individual practice association and the individual provider terminates, whichever is applicable. (d) For the purposes of this article, “economic profiling” shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.
Section 1368(a)	Every plan shall do all of the following: (1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate. (2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted. (3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format. (4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following: (i) That the grievance has been received.

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	(ii) The date of receipt. (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance. (B)(i) Grievances received by telephone, by facsimile, by email, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint: (I) The date of the call. (II) The name of the complainant. (III) The complainant's member identification number. (IV) The nature of the grievance. (V) The nature of the resolution. (VI) The name of the plan representative who took the call and resolved the grievance. (ii) For health plan contracts in the individual, small group, or large group markets, a health care service plan's response to grievances subject to Section 1367.24 shall also comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This paragraph shall not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code. (5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that cover-age.

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	(6) For grievances involving the cancellation, rescission, or nonrenewal of a health care service plan contract, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the health care service plan contract until a final determination of the enrollee's or subscriber's request for review has been made by the health care service plan or the director pursuant to Section 1365 and this section. This paragraph shall not apply if the health care service plan cancels or fails to renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a) of Section 1365. (7) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.
Section 1370	Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.
Section 1370.2	Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider. This health care provider or the medical director shall review the appeal and, if he or she determines that he or she is competent to evaluate the specific clinical issues presented in the claim, shall make a determination on the appealed claim. If the health care provider or medical director determines that he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented in the claim. For the purposes of this section, "competent to evaluate the specific clinical issues" means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized. The plan shall determine whether or not to use an appropriate specialist provider in the review of contested claims.
Section 1371(a)	(1) A health care service plan, including a specialized health care service plan, shall reimburse claims or a portion of a claim, whether in state or out of state, as soon as practicable, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the

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	claim by the health care service plan, unless the claim or portion thereof is contested by the plan, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. (2) If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. A plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee. (3) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided. (4) If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per

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	annum beginning with the first calendar day after the 30-or 45-working-day period.
Section 1371(c)	The obligation of a specialized health care service plan to comply with this section is not waived when the specialized health care service plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.
Section 1371.31(a)(1)	For services rendered subject to Section 1371.9, effective July 1, 2017, unless otherwise agreed to by the noncontracting individual health professional and the plan, the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, “average contracted rate” means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. This subdivision does not apply to subdivision (c) of Section 1371.9 or subdivision (b) of this section.
Section 1371.35	(a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b). (b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant’s address of record within the respective 30 or 45 working days after receipt,

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	the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30-or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor. (c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete. (d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider’s control. A plan shall specify, in a written notice sent to the provider

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	within the respective 30-or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim. (e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30-or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor. (f) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities. (g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim. (h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section. (i) This section shall not apply to capitated payments. (j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999. (k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371. (l) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

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Section 1371.36	(a) A health care service plan shall not deny payment of a claim on the basis that the plan, medical group, independent practice association, or other contracting entity did not provide authorization for health care services that were provided in a licensed acute care hospital and that were related to services that were previously authorized, if all of the following conditions are met: (1) It was medically necessary to provide the services at the time. (2) The services were provided after the plan's normal business hours. (3) The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made. (b) This section shall not apply to investigational or experimental therapies, or other noncovered services.
Section 1371.37(a)-(c)	(a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section. (b) Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan to determine whether it has engaged in an unfair payment pattern. (c) An "unfair payment pattern," as used in this section, means any of the following: (1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays. (2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims. (3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35. (4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.
Section 1371.38	(a) The department shall, on or before July 1, 2001, adopt regulations that ensure that plans have adopted a dispute resolution mechanism pursuant to subdivision (h) of Section 1367. The regulations shall require that any dispute resolution mechanism of a plan is fair, fast, and cost-effective for contracting and non-contracting providers and define the term "complete and accurate claim, including attachments and supplemental information or documentation."

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	(b) On or before December 31, 2001, the department shall report to the Governor and the Legislature its recommendations for any additional statutory requirements relating to plan and provider dispute resolution mechanisms.
Section 1371.4	(a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision. (b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition. (c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition. (d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care

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	of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied. (e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers. (f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician. (g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee re-quires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization. (h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate time-frames for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan. (i) The definitions set forth in Section 1317.1 shall control the construction of this section. (j)(1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital. (2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

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	(A) The health care service plan authorizes the hospital to provide poststabilization care. (B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1). (C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care. (3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon. (4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health. (5) For purposes of this section, "poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.
Section 1371.5	(a) No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply: (1) The request was made for an emergency medical condition and ambulance transport services were required. (2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services. (b) As used in this section, "emergency medical condition" has the same meaning as in Section 1317.1. (c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance. (d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance

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	transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.
Section 1371.8	A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan. The Legislature finds and declares that by adopting the amendments made to this section by Assembly Bill 1324 of the 2007-08 Regular Session it does not intend to instruct a court as to whether or not the amendments are existing law.
Section 1371.9(a) – (d)	(a)(1) Except as provided in subdivision (c), a health care service plan contract issued, amended, or renewed on or after July 1, 2017, shall provide that if an enrollee receives covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount." (2) An enrollee shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting individual health professional, the plan shall inform the enrollee and the noncontracting individual health professional of the in-network cost-sharing amount owed by the enrollee. (3) A noncontracting individual health professional shall not bill or collect any amount from the enrollee for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting individual health professional to the enrollee prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the enrollee that the

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	enrollee shall not pay until he or she is informed by his or her health care service plan of any applicable cost sharing. (4)(A) If the noncontracting individual health professional has received more than the in-network cost-sharing amount from the enrollee for services subject to this section, the noncontracting individual health professional shall refund any overpayment to the enrollee within 30 calendar days after receiving payment from the enrollee. (B) If the noncontracting individual health professional does not refund any overpayment to the enrollee within 30 calendar days after being informed of the enrollee's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the enrollee. (C) A noncontracting individual health professional shall automatically include in his or her refund to the enrollee all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount. (b) Except for services subject to subdivision (c), the following shall apply: (1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006. (2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional. (3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the enrollee." (c) For services subject to this section, if an enrollee has a health care service plan that includes coverage for out-of-network benefits, a noncontracting individual health professional may bill or collect from the enrollee the out-of-network cost sharing, if applicable, only when the enrollee consents in writing and that written consent demonstrates satisfaction of all the following criteria: (1) At least 24 hours in advance of care, the enrollee shall consent in writing to receive services from the identified noncontracting individual health professional. (2) The consent shall be obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or

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	any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the enrollee is being prepared for surgery or any other procedure. (3) At the time consent is provided, the noncontracting individual health professional shall give the enrollee a written estimate of the enrollee's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional shall not attempt to collect more than the estimated amount without receiving separate written consent from the enrollee or the enrollee's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate. (4) The consent shall advise the enrollee that he or she may elect to seek care from a contracted provider or may contact the enrollee's health care service plan in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs. (5) The consent and estimate shall be provided to the enrollee in the language spoken by the enrollee, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552. (6) The consent shall also advise the enrollee that any costs incurred as a result of the enrollee's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits. (d) A noncontracting individual health professional who fails to comply with the requirements of subdivision (c) has not obtained written consent for purposes of this section. Under those circumstances, subdivisions (a) and (b) shall apply and subdivision (c) shall not apply.
Section 1375.1(a)	Every plan shall have and shall demonstrate to the director that it has all of the following: (1) A fiscally sound operation and adequate provision against the risk of insolvency. (2) Assumed full financial risk on a prospective basis for the provision of covered health care services, except that a plan may obtain insurance or make other arrangements for the cost of providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year, for the cost of covered health care services provided to its members other than through the plan

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	because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year. (3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims, including those telehealth services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan. Except as provided in Section 1371, a procedure meeting the requirements of Subchapter G of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.
Section 1399.55	Health care service plans shall, upon rejecting a claim from a health care provider or a patient, and upon their demand, disclose the specific rationale used in determining why the claim was rejected. Nothing in this section is intended to expand or restrict the ability of a health care provider or a patient from having health care coverage approved in advance of services.
Section 1399.56	Compensation of a person retained by a health care service plan to review claims for health care services shall not be based on either of the following: (a) A percentage of the amount by which a claim is reduced for payment. (b) The number of claims or the cost of services for which the person has denied authorization or payment.
Rule 1300.67.3	(a) The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include: (1) separation of medical services from fiscal and administrative management sufficient to assure the Director that medical decisions will not be unduly influenced by fiscal and administrative management, (2) staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business, and (3) written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.
Rule 1300.68(d)	The plan shall respond to grievances as follows: (1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of

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	receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance. (2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance. (3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law. (4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814. (5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review. (6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical

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	records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision. (7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act. (8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).
Rule 1300.71(a)(1)-(2)	(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. (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 (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:

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	(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 or its successors) 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: (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.
Rule 1300.71(a)(3)	Except as required by section 1300.71.31, "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: (i) 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

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	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.
Rule 1300.71(a)(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.
Rule 1300.71(a)(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 procedures may 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; (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;

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	(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; (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

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	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-month period. (U) A pattern of failure to pay noncontracting individual health professionals the reimbursement described in section 1300.71.31 and required pursuant to section 1371.31 of the Knox-Keene Act for health care services subject to section 1371.9 of the Knox-Keene Act. (V) A pattern of failure to determine the average contracted rate for health care services subject to section 1371.9 of the Knox-Keene Act in a manner consistent with section 1300.71.31.
Rule 1300.71(a)(9)-(13)	(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

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	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.
Rule 1300.71(b)(1)-(3)	(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 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.

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	(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.
Rule 1300.71(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 (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.
Rule 1300.71(d)	(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

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	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 1300.71.38of 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 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.
Rule 1300.71(e)	(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

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	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, and1300.77.4 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 sections1371, 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, and1300.77.4 of title 28; (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

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	medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process for a de 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 sections1371, 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, and1300.77.4 of title 28.
Rule 1300.71(g) – (j)	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.

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	(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 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 deny 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

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	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 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).
Rule 1300.71(l)-(p)	(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

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	(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 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

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	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. 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.
Rule 1300.71(q)	(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),

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	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. (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.
Rule 1300.71.31(b)	For all health care services subject to section 1371.9 of the Knox-Keene Act, payers shall comply with subdivision (e) and do the following: (1) For health care services most frequently subject to 1371.9, payers shall use the methodology described in this section to determine the average contracted rate; or (2) For health care services that do not fall under subdivision (b)(1), the payer may, but is not required to, use the methodology described in this section to determine the average contracted rate. If the payer uses a different methodology, that different methodology shall be a reasonable method of determining the

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	average contracted commercial rates paid by the payer for the same or similar services in the geographic region, in the applicable calendar year.
Rule 1300.71.38	All health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The plan and the plan's capitated provider may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections 1367(h), 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. Arbitration shall not be deemed a provider dispute or a provider dispute resolution mechanism for the purposes of this section. (a) Definitions: (1) "Contracted Provider Dispute'' means a contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and: (A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; (B) If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and (C) If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

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	(2) “Non-Contracted Provider Dispute’’ means a non-contracted provider’s written notice to the plan or the plan’s capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider’s name, the provider’s identification number, contact information and: (A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect. (B) If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider’s position thereon. (3) “Date of receipt’’ means the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan’s or the plan’s capitated provider’s designated dispute resolution office or post office box. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. (4) “Date of Determination’’ means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, 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 Determination, the Department may consider, when auditing the plan’s or the plan’s capitated provider’s provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and 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. (5) “Plan’’ for the purposes of this section means a licensed health care service plan and its contracted claims processing organization(s). (b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan’s capitated provider contests, adjusts or denies a claim, it shall inform the provider of the

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	availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for fling a provider dispute. (c) Submission of Provider Disputes. The plan and the plan's capitated provider shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes that, at a minimum, provide that: (1) Provider disputes be submitted utilizing the same number assigned to the original claim; thereafter the plan or the plan's capitated provider shall process and track the provider dispute in a manner that allows the plan, the plan's capitated provider, the provider and the Department to link the provider dispute with the number assigned to the original claim. (2) Contracted Provider Disputes be submitted in a manner consistent with procedures disclosed in sections 1300.71(l)(1) - (4). (3) Non-contracted Provider Disputes be submitted in a manner consistent with the directions for obtaining forms and instructions for fling a provider dispute attached to the plan's or the plan's capitated provider's notice that the subject claim has been denied, adjusted or contested or pursuant to the directions for fling Non-contracted Provider Disputes contained on the plan's or the plan's capitated provider's website. (4) The plan shall resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the plan's consumer grievance process and not in the plan's or the plan's capitated provider's dispute resolution mechanism. The plan may verify the enrollee's authorization to proceed with the grievance prior to submitting the complaint to the plan's consumer grievance process. When a provider submits a dispute on behalf of an enrollee or a group of enrollees, the provider shall be deemed to be joining with or assisting the enrollee within the meaning of section 1368 of the Health and Safety Code. (d) Time Period for Submission. (1) Neither the plan nor the plan's capitated provider that pays claims, except as required by any state or federal law or regulation, shall impose a deadline for the receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute that is less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider, neither the

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	plan nor the plan's capitated provider shall impose a deadline for the receipt of a dispute that is less than 365 days from the plan's or the plan's capitated provider's most recent action or in the case of inaction that is less than 365 days after the most recent Time for Contesting or Denying Claims has expired. (2) The plan or the plan's capitated provider may return any provider dispute lacking the information enumerated in either section (a)(1) or (a)(2), if the information is in the possession of the provider and is not readily accessible to the plan or the plan's capitated provider. Along with any returned provider dispute, the plan or the plan's capitated provider shall clearly identify in writing the missing information necessary to resolve the dispute consistent with sections 1300.71(a)(10) and (11) and 1300.71(d)(1), (2) and (3). Except in situation where the claim documentation has been returned to the provider, no plan or a plan's capitated provider shall request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the plan or the plan's capitated provider as part of the claims adjudication process. (3) A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information. (e) Time Period for Acknowledgment. A plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute: (1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or (2) In the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes. (f) Time Period for Resolution and Written Determination. The plan or the plan's capitated provider shall resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written determination stating the pertinent facts and explaining the reasons for its determination

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	within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. Copies of provider disputes and determinations, including all notes, documents and other information upon which the plan or the plan's capitated provider relied to reach its decision, and all reports and related information shall be retained for at least the period specified in section 1300.85.1 of title 28. (g) Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 of the Health and Safety Code and section 1300.71 of title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement'' as forth in section 1300.71(g). (h) Designation of Plan Officer. The plan and the plan's capitated provider shall each designate a principal officer, as defined by section 1300.45(o) of title 28, to be primarily responsible for the maintenance of their respective provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care. The designated principal officer shall be responsible for preparing, the reports and disclosures as specified in sections 1300.71(e)(3) and (q) and 1300.71.38(k) of title 28. (i) No Discrimination. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute. (j) Dispute Resolution Costs. A provider dispute received under this section shall be received, handled and resolved by the plan and the plan's capitated provider without charge to the provider. Notwithstanding the foregoing, the plan and the plan's capitated provider shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism. (k) Required Reports. Beginning with the 2004 calendar year and for each subsequent year, the plan shall submit to the Department no more than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims Payment and Dispute Resolution

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	Mechanism Report,'' described in part in Section 1300.71(q) of this regulation, on an electronic form to be supplied by the Department Managed Health Care pursuant to section 1300.41.8 of title 28 containing the following, which shall be reported based upon the date of receipt of the provider dispute or amended provider dispute: (1) Information on the number and types of providers using the dispute resolution mechanism; (2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and (3) A detailed, informative statement disclosing any emerging or established patterns of provider disputes and 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) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant section 1007 of title 28. (4) The first report shall be due on or before January 15, 2005. (l) Confidentiality. (1) The plan's Annual Plan Claims Payment and Dispute Resolution Mechanism Report to the Department regarding its dispute resolution mechanism shall be public information except for information disclosed pursuant to section (k)(3) above, that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis. (2) The plan's quarterly disclosures pursuant to section 1300.71(q)(1) shall be public information except for the information relating to the plan's corrective action strategies that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis. (m) Review and Enforcement. (1) The Department shall review the plan's and the plan's capitated provider's provider dispute resolution mechanism(s), including the records of provider disputes filed with the plan and remedial action taken pursuant to section 1300.71.38(m)(3),

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	through 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 unfair provider dispute resolution mechanism(s). (2) The failure of a plan to comply with the requirements of this regulation shall be 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 Act and this regulation are subject to enforcement action whether or not remediated, although a plan's self-identification and self-initiated remediation of violations or deficiencies may be considered in determining the appropriate penalty.
Rule 1300.74.30(a)-(c)	(a) Plan enrollees may request independent medical review pursuant to this regulation for decisions that are eligible for independent medical review under Article 5.55 and section 1370.4 of the Act. The independent medical review process shall resolve decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. Specialized plans shall provide for independent medical reviews under this section if a covered service relates to the practice of medicine or is provided pursuant to a contract with a health plan providing medical, surgical and hospital services. The Department shall be the final arbiter when there is a question as to whether a dispute over a health care service is eligible for independent medical review, and whether extraordinary and compelling circumstances exist that waive the requirement that the enrollee first participate in the plan's grievance system. (b) An enrollee may apply for an independent medical review under the conditions specified in Section 1374.30(j) of the Act. The Department may waive the requirement that the enrollee participate in the plan's grievance process if the Department determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the enrollee. (c) In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and

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	stabilize the enrollee's condition. For purposes of this section "emergency services'' are services for emergency medical conditions as defined in section 1300.71.4 of title 28, and "urgent services'' are all services, except emergency services, where the enrollee has obtained the services without prior authorization from the plan, or from a contracting provider.
Rule 1300.75.4.1(b)	(b) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization shall require the plan to disclose, on or before October 1, 2001, and annually thereafter on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, and further specify the Medicare RBRVS year if RBRVS is the methodology used for fee schedule development. For any proprietary fee schedule, the contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.
Rule 1300.77.2	(a) Each plan subject to subdivision (b) of Section 1377 shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Director. Such method may include a lag study as defined and illustrated in subsection (c), an actuarial estimate as defined in subsection (d), or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred and unreported claims. (b) Working papers which support the incurred and unreported claims calculation shall be maintained as part of the records of the plan. Lag study working papers shall include a detailed allocation of all claims received each month to the various months in which the services were performed. Actuarial estimate working papers must detail all underlying assumptions and calculations in establishing the actuarial rate. Any other method used to determine the amount of incurred and unreported claims must be supported by adequate working papers, schedules or reports which detail all aspects of the incurred and unreported calculation. (c) A "lag study'' is a schedule which analyzes historical claims information on an ongoing basis to determine the length of time

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	lag between the date of service and the date a claim is submitted to the plan for payment. Such a study distributes all claims received each month in which the services were performed. (d) An “actuarial estimate’’ is a calculation of incurred and unreported claims which is based on adequate and reasonable assumptions with respect to risk factors and trends which have been found to be applicable to the plan, such as utilization patterns of the plan’s enrollees, the average benefit which will be payable, the enrollment mix in terms of age and sex of enrollees and geographic location, actual plan contract experience, and any other factors reasonably believed to affect the amount of incurred and unreported claims. Actuarial estimates must be supported by an actuarial certification, consisting of a signed declaration of any actuary who is a member in good standing of the American Academy of Actuaries in which such actuary states that the assumptions used in calculating the incurred and unreported claims are appropriate and reasonable. If the plan employs an actuarial study to estimate the amount of the incurred and unreported claims, it must compare the actual claims amounts to those estimated, and make adjustments at least quarterly whenever a 5% difference from actual experience is noted. (e) A plan may employ any other unobjectionable alternative method of estimating the amount of incurred and unreported claims other than the “lag study’’ or “actuarial estimate,’’ so long as such alternative method accurately estimates incurred and unreported claims. For example, a plan may receive daily reports of actual hospital admissions and referrals, thereby permitting the plan to compare these reports to the actual invoices and calculate the estimated amount due hospitals for the enrollees whose claims had not been received by the plan at that time.
Rule 1300.77.4	Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim. Although any categories for status-determination held unobjectionable by the Director may be used, for the purposes of this section, the following status-determination categories, as a group, shall be presumptively reasonable: (1) to be processed, (2) processed, waiting for payment, (3) pending, waiting for approval for payment or denial,

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	(4) pending, waiting for additional information, (5) denied, (6) paid, and, if appropriate, (7) other. These procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Director.