

AMENDED IN SENATE APRIL 26, 2010

**SENATE BILL**

**No. 1169**

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**Introduced by Senator Lowenthal**

February 18, 2010

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An act to amend Sections 1367.01, 1371, 1371.35, and 1374.72 of, and to add Section 1370.8 to, the Health and Safety Code, and to amend Sections 10123.13, 10123.135, 10123.147, and 10144.5 of, and to add Section 10123.125 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1169, as amended, Lowenthal. Health care coverage: claims: prior authorization: mental health.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to have written policies and procedures establishing the process by which the plans or insurers prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers of health care services for enrollees or insureds. Existing law requires health care service plans and health insurers to reimburse uncontested claims within 30 or 45 working days and specifies that a claim is contested if the plan or insurer has not received a completed claim and all information necessary to determine payer liability.

This bill would require plans and insurers to assign a tracking number to a claim or provider request for authorization, upon receipt thereof, and to provide acknowledgment of receipt thereof, including identification of the tracking number, to both the provider and the enrollee or insured, as specified. With respect to claims that are contested on the basis that the plan or insurer has not received all information necessary to determine payer liability for the claim, the bill would require the plan or insurer to provide acknowledgment of receipt of any of that information within 3 working days, as specified.

Existing law requires a health care service plan contract or health insurance policy to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions that apply to other medical conditions. Existing law specifies that these terms and conditions include maximum lifetime benefits, copayments, and individual family deductibles.

This bill would ~~instead require that~~ *specify that these terms and conditions include, but are not limited to,* any form of treatment limitation, or other action by a plan or insurer that may limit the receipt of the covered benefits described above, ~~be applied under the same terms and conditions that apply to other benefits under the contract or policy.~~

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 1367.01 of the Health and Safety Code
- 2 is amended to read:
- 3 1367.01. (a) A health care service plan and any entity with
- 4 which it contracts for services that include utilization review or
- 5 utilization management functions, that prospectively,

1 retrospectively, or concurrently reviews and approves, modifies,  
2 delays, or denies, based in whole or in part on medical necessity,  
3 requests by providers prior to, retrospectively, or concurrent with  
4 the provision of health care services to enrollees, or that delegates  
5 these functions to medical groups or independent practice  
6 associations or to other contracting providers, shall comply with  
7 this section.

8 (b) (1) A health care service plan that is subject to this section  
9 shall have written policies and procedures establishing the process  
10 by which the plan prospectively, retrospectively, or concurrently  
11 reviews and approves, modifies, delays, or denies, based in whole  
12 or in part on medical necessity, requests by providers of health  
13 care services for plan enrollees. These policies and procedures  
14 shall ensure that decisions based on the medical necessity of  
15 proposed health care services are consistent with criteria or  
16 guidelines that are supported by clinical principles and processes.  
17 These criteria and guidelines shall be developed pursuant to Section  
18 1363.5. These policies and procedures, and a description of the  
19 process by which the plan reviews and approves, modifies, delays,  
20 or denies requests by providers prior to, retrospectively, or  
21 concurrent with the provision of health care services to enrollees,  
22 shall be filed with the director for review and approval, and shall  
23 be disclosed by the plan to providers and enrollees upon request,  
24 and by the plan to the public upon request.

25 (2) Upon receipt of a request by a provider prior to,  
26 retrospectively, or concurrent with, the provision of health care  
27 services to an enrollee, a health care service plan subject to this  
28 section shall assign a tracking number to the request and shall  
29 provide acknowledgment of receipt of the request to both the  
30 provider and the enrollee. The acknowledgment of receipt shall  
31 identify the assigned tracking number and shall be provided via  
32 electronic mail, unless the provider or enrollee has opted out of  
33 the electronic method of transmittal and requested that all  
34 acknowledgments of receipt be transmitted in writing. In the case  
35 of an orally submitted request, the acknowledgment of receipt shall  
36 also be provided orally to the submitting provider. All  
37 communications regarding the request, including, but not limited  
38 to, the communications or responses identified in subdivision (h),  
39 shall reference the tracking number assigned pursuant to this  
40 paragraph.

1 (c) A health care service plan subject to this section, except a  
2 plan that meets the requirements of Section 1351.2, shall employ  
3 or designate a medical director who holds an unrestricted license  
4 to practice medicine in this state issued pursuant to Section 2050  
5 of the Business and Professions Code or pursuant to the  
6 Osteopathic Act, or, if the plan is a specialized health care service  
7 plan, a clinical director with California licensure in a clinical area  
8 appropriate to the type of care provided by the specialized health  
9 care service plan. The medical director or clinical director shall  
10 ensure that the process by which the plan reviews and approves,  
11 modifies, or denies, based in whole or in part on medical necessity,  
12 requests by providers prior to, retrospectively, or concurrent with  
13 the provision of health care services to enrollees, complies with  
14 the requirements of this section.

15 (d) If health plan personnel, or individuals under contract to the  
16 plan to review requests by providers, approve the provider's  
17 request, pursuant to subdivision (b), the decision shall be  
18 communicated to the provider pursuant to subdivision (h).

19 (e) No individual, other than a licensed physician or a licensed  
20 health care professional who is competent to evaluate the specific  
21 clinical issues involved in the health care services requested by  
22 the provider, may deny or modify requests for authorization of  
23 health care services for an enrollee for reasons of medical necessity.  
24 The decision of the physician or other health care professional  
25 shall be communicated to the provider and the enrollee pursuant  
26 to subdivision (h).

27 (f) The criteria or guidelines used by the health care service  
28 plan to determine whether to approve, modify, or deny requests  
29 by providers prior to, retrospectively, or concurrent with, the  
30 provision of health care services to enrollees shall be consistent  
31 with clinical principles and processes. These criteria and guidelines  
32 shall be developed pursuant to the requirements of Section 1363.5.

33 (g) If the health care service plan requests medical information  
34 from providers in order to determine whether to approve, modify,  
35 or deny requests for authorization, the plan shall request only the  
36 information reasonably necessary to make the determination.

37 (h) In determining whether to approve, modify, or deny requests  
38 by providers prior to, retrospectively, or concurrent with the  
39 provision of health care services to enrollees, based in whole or

1 in part on medical necessity, a health care service plan subject to  
2 this section shall meet the following requirements:

3 (1) Decisions to approve, modify, or deny, based on medical  
4 necessity, requests by providers prior to, or concurrent with the  
5 provision of health care services to enrollees that do not meet the  
6 requirements for the 72-hour review required by paragraph (2),  
7 shall be made in a timely fashion appropriate for the nature of the  
8 enrollee's condition, not to exceed five business days from the  
9 plan's receipt of the information reasonably necessary and  
10 requested by the plan to make the determination. In cases where  
11 the review is retrospective, the decision shall be communicated to  
12 the individual who received services, or to the individual's  
13 designee, within 30 days of the receipt of information that is  
14 reasonably necessary to make this determination, and shall be  
15 communicated to the provider in a manner that is consistent with  
16 current law. For purposes of this section, retrospective reviews  
17 shall be for care rendered on or after January 1, 2000.

18 (2) When the enrollee's condition is such that the enrollee faces  
19 an imminent and serious threat to his or her health, including, but  
20 not limited to, the potential loss of life, limb, or other major bodily  
21 function, or the normal timeframe for the decisionmaking process,  
22 as described in paragraph (1), would be detrimental to the enrollee's  
23 life or health or could jeopardize the enrollee's ability to regain  
24 maximum function, decisions to approve, modify, or deny requests  
25 by providers prior to, or concurrent with, the provision of health  
26 care services to enrollees, shall be made in a timely fashion  
27 appropriate for the nature of the enrollee's condition, not to exceed  
28 72 hours after the plan's receipt of the information reasonably  
29 necessary and requested by the plan to make the determination.  
30 Nothing in this section shall be construed to alter the requirements  
31 of subdivision (b) of Section 1371.4. Notwithstanding Section  
32 1371.4, the requirements of this division shall be applicable to all  
33 health plans and other entities conducting utilization review or  
34 utilization management.

35 (3) Decisions to approve, modify, or deny requests by providers  
36 for authorization prior to, or concurrent with, the provision of  
37 health care services to enrollees shall be communicated to the  
38 requesting provider within 24 hours of the decision. Except for  
39 concurrent review decisions pertaining to care that is underway,  
40 which shall be communicated to the enrollee's treating provider

1 within 24 hours, decisions resulting in denial, delay, or  
2 modification of all or part of the requested health care service shall  
3 be communicated to the enrollee in writing within two business  
4 days of the decision. In the case of concurrent review, care shall  
5 not be discontinued until the enrollee's treating provider has been  
6 notified of the plan's decision and a care plan has been agreed  
7 upon by the treating provider that is appropriate for the medical  
8 needs of that patient.

9 (4) Communications regarding decisions to approve requests  
10 by providers prior to, retrospectively, or concurrent with the  
11 provision of health care services to enrollees shall specify the  
12 specific health care service approved. Responses regarding  
13 decisions to deny, delay, or modify health care services requested  
14 by providers prior to, retrospectively, or concurrent with the  
15 provision of health care services to enrollees shall be  
16 communicated to the enrollee in writing, and to providers initially  
17 by telephone or facsimile, except with regard to decisions rendered  
18 retrospectively, and then in writing, and shall include a clear and  
19 concise explanation of the reasons for the plan's decision, a  
20 description of the criteria or guidelines used, and the clinical  
21 reasons for the decisions regarding medical necessity. Any written  
22 communication to a physician or other health care provider of a  
23 denial, delay, or modification of a request shall include the name  
24 and telephone number of the health care professional responsible  
25 for the denial, delay, or modification. The telephone number  
26 provided shall be a direct number or an extension, to allow the  
27 physician or health care provider easily to contact the professional  
28 responsible for the denial, delay, or modification. Responses shall  
29 also include information as to how the enrollee may file a grievance  
30 with the plan pursuant to Section 1368, and in the case of Medi-Cal  
31 enrollees, shall explain how to request an administrative hearing  
32 and aid paid pending under Sections 51014.1 and 51014.2 of Title  
33 22 of the California Code of Regulations.

34 (5) If the health care service plan cannot make a decision to  
35 approve, modify, or deny the request for authorization within the  
36 timeframes specified in paragraph (1) or (2) because the plan is  
37 not in receipt of all of the information reasonably necessary and  
38 requested, or because the plan requires consultation by an expert  
39 reviewer, or because the plan has asked that an additional  
40 examination or test be performed upon the enrollee, provided the

1 examination or test is reasonable and consistent with good medical  
2 practice, the plan shall, immediately upon the expiration of the  
3 timeframe specified in paragraph (1) or (2) or as soon as the plan  
4 becomes aware that it will not meet the timeframe, whichever  
5 occurs first, notify the provider and the enrollee, in writing, that  
6 the plan cannot make a decision to approve, modify, or deny the  
7 request for authorization within the required timeframe, and specify  
8 the information requested but not received, or the expert reviewer  
9 to be consulted, or the additional examinations or tests required.  
10 The plan shall also notify the provider and enrollee of the  
11 anticipated date on which a decision may be rendered. Upon receipt  
12 of all information reasonably necessary and requested by the plan,  
13 the plan shall approve, modify, or deny the request for authorization  
14 within the timeframes specified in paragraph (1) or (2), whichever  
15 applies.

16 (6) If the director determines that a health care service plan has  
17 failed to meet any of the timeframes in this section, or has failed  
18 to meet any other requirement of this section, the director may  
19 assess, by order, administrative penalties for each failure. A  
20 proceeding for the issuance of an order assessing administrative  
21 penalties shall be subject to appropriate notice to, and an  
22 opportunity for a hearing with regard to, the person affected, in  
23 accordance with subdivision (a) of Section 1397. The  
24 administrative penalties shall not be deemed an exclusive remedy  
25 for the director. These penalties shall be paid to the Managed Care  
26 Administrative Fines and Penalties Fund and shall be used for the  
27 purposes specified in Section 1341.45.

28 (i) A health care service plan subject to this section shall  
29 maintain telephone access for providers to request authorization  
30 for health care services.

31 (j) A health care service plan subject to this section that reviews  
32 requests by providers prior to, retrospectively, or concurrent with,  
33 the provision of health care services to enrollees shall establish,  
34 as part of the quality assurance program required by Section 1370,  
35 a process by which the plan's compliance with this section is  
36 assessed and evaluated. The process shall include provisions for  
37 evaluation of complaints, assessment of trends, implementation  
38 of actions to correct identified problems, mechanisms to  
39 communicate actions and results to the appropriate health plan

1 employees and contracting providers, and provisions for evaluation  
2 of any corrective action plan and measurements of performance.

3 (k) The director shall review a health care service plan's  
4 compliance with this section as part of its periodic onsite medical  
5 survey of each plan undertaken pursuant to Section 1380, and shall  
6 include a discussion of compliance with this section as part of its  
7 report issued pursuant to that section.

8 (l) This section shall not apply to decisions made for the care  
9 or treatment of the sick who depend upon prayer or spiritual means  
10 for healing in the practice of religion as set forth in subdivision  
11 (a) of Section 1270.

12 (m) Nothing in this section shall cause a health care service plan  
13 to be defined as a health care provider for purposes of any provision  
14 of law, including, but not limited to, Section 6146 of the Business  
15 and Professions Code, Sections 3333.1 and 3333.2 of the Civil  
16 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the  
17 Code of Civil Procedure.

18 SEC. 2. Section 1370.8 is added to the Health and Safety Code,  
19 to read:

20 1370.8. Upon receipt of a claim, a health care service plan shall  
21 assign a tracking number to the claim and shall provide  
22 acknowledgment of receipt of the claim to both the provider and  
23 the enrollee. The acknowledgment of receipt shall identify the  
24 assigned tracking number and shall be provided via electronic  
25 mail, unless the provider or enrollee has opted out of the electronic  
26 method of transmittal and requested that all acknowledgments of  
27 receipt be transmitted in writing. In the case of an orally submitted  
28 claim, the acknowledgment of receipt shall also be provided orally  
29 to the submitting provider or enrollee. All communications  
30 regarding the claim shall reference the tracking number assigned  
31 pursuant to this section.

32 SEC. 3. Section 1371 of the Health and Safety Code is amended  
33 to read:

34 1371. (a) A health care service plan, including a specialized  
35 health care service plan, shall reimburse claims or any portion of  
36 any claim, whether in state or out of state, as soon as practical, but  
37 no later than 30 working days after receipt of the claim by the  
38 health care service plan, or if the health care service plan is a health  
39 maintenance organization, 45 working days after receipt of the  
40 claim by the health care service plan, unless the claim or portion

1 thereof is contested by the plan in which case the claimant shall  
2 be notified, in writing, that the claim is contested or denied, within  
3 30 working days after receipt of the claim by the health care service  
4 plan, or if the health care service plan is a health maintenance  
5 organization, 45 working days after receipt of the claim by the  
6 health care service plan. The notice that a claim is being contested  
7 shall identify the portion of the claim that is contested and the  
8 specific reasons for contesting the claim.

9 (b) If an uncontested claim is not reimbursed by delivery to the  
10 claimants' address of record within the respective 30 or 45 working  
11 days after receipt, interest shall accrue at the rate of 15 percent per  
12 annum beginning with the first calendar day after the 30- or  
13 45-working-day period. A health care service plan shall  
14 automatically include in its payment of the claim all interest that  
15 has accrued pursuant to this section without requiring the claimant  
16 to submit a request for the interest amount. Any plan failing to  
17 comply with this requirement shall pay the claimant a ten-dollar  
18 (\$10) fee.

19 (c) For the purposes of this section, a claim, or portion thereof,  
20 is reasonably contested if the plan has not received the completed  
21 claim and all information necessary to determine payer liability  
22 for the claim, or has not been granted reasonable access to  
23 information concerning provider services. Information necessary  
24 to determine payer liability for the claim includes, but is not limited  
25 to, reports of investigations concerning fraud and  
26 misrepresentation, and necessary consents, releases, and  
27 assignments, a claim on appeal, or other information necessary for  
28 the plan to determine the medical necessity for the health care  
29 services provided.

30 (d) If a claim or portion thereof is contested on the basis that  
31 the plan has not received all information necessary to determine  
32 payer liability for the claim or portion thereof and notice has been  
33 provided pursuant to this section both of the following shall apply:

34 (1) Within three working days of receipt of any of this additional  
35 information, the plan shall provide acknowledgment of receipt of  
36 that information to the claimant. The acknowledgment of receipt  
37 shall be provided via electronic mail unless the claimant has opted  
38 out of the electronic method of transmittal and requested that all  
39 acknowledgments of receipt be transmitted in writing. The

1 acknowledgment of receipt shall include the tracking number  
2 assigned to the claim pursuant to Section 1370.8.

3 (2) The plan shall have 30 working days or, if the health care  
4 service plan is a health maintenance organization, 45 working days  
5 after receipt of all of the information necessary to determine payer  
6 liability to complete reconsideration of the claim. If a plan has  
7 received all of the information necessary to determine payer  
8 liability for a contested claim and has not reimbursed a claim it  
9 has determined to be payable within 30 working days of the receipt  
10 of that information, or if the plan is a health maintenance  
11 organization, within 45 working days of receipt of that information,  
12 interest shall accrue and be payable at a rate of 15 percent per  
13 annum beginning with the first calendar day after the 30- or  
14 ~~45-working-day~~ 45-working-day period.

15 (e) The obligation of the plan to comply with this section shall  
16 not be deemed to be waived when the plan requires its medical  
17 groups, independent practice associations, or other contracting  
18 entities to pay claims for covered services.

19 SEC. 4. Section 1371.35 of the Health and Safety Code is  
20 amended to read:

21 1371.35. (a) A health care service plan, including a specialized  
22 health care service plan, shall reimburse each complete claim, or  
23 portion thereof, whether in state or out of state, as soon as practical,  
24 but no later than 30 working days after receipt of the complete  
25 claim by the health care service plan, or if the health care service  
26 plan is a health maintenance organization, 45 working days after  
27 receipt of the complete claim by the health care service plan.  
28 However, a plan may contest or deny a claim, or portion thereof,  
29 by notifying the claimant, in writing, that the claim is contested  
30 or denied, within 30 working days after receipt of the claim by the  
31 health care service plan, or if the health care service plan is a health  
32 maintenance organization, 45 working days after receipt of the  
33 claim by the health care service plan. The notice that a claim, or  
34 portion thereof, is contested shall identify the portion of the claim  
35 that is contested, by revenue code, and the specific information  
36 needed from the provider to reconsider the claim. The notice that  
37 a claim, or portion thereof, is denied shall identify the portion of  
38 the claim that is denied, by revenue code, and the specific reasons  
39 for the denial. A plan may delay payment of an uncontested portion  
40 of a complete claim for reconsideration of a contested portion of

1 that claim so long as the plan pays those charges specified in  
2 subdivision (b).

3 (b) If a complete claim, or portion thereof, that is neither  
4 contested nor denied, is not reimbursed by delivery to the  
5 claimant's address of record within the respective 30 or 45 working  
6 days after receipt, the plan shall pay the greater of fifteen dollars  
7 (\$15) per year or interest at the rate of 15 percent per annum  
8 beginning with the first calendar day after the 30- or ~~45-working~~  
9 ~~day~~ 45-working-day period. A health care service plan shall  
10 automatically include the fifteen dollars (\$15) per year or interest  
11 due in the payment made to the claimant, without requiring a  
12 request therefor.

13 (c) For the purposes of this section, a claim, or portion thereof,  
14 is reasonably contested if the plan has not received the completed  
15 claim. A paper claim from an institutional provider shall be deemed  
16 complete upon submission of a legible emergency department  
17 report and a completed UB 92 or other format adopted by the  
18 National Uniform Billing Committee, and reasonable relevant  
19 information requested by the plan within 30 working days of receipt  
20 of the claim. An electronic claim from an institutional provider  
21 shall be deemed complete upon submission of an electronic  
22 equivalent to the UB 92 or other format adopted by the National  
23 Uniform Billing Committee, and reasonable relevant information  
24 requested by the plan within 30 working days of receipt of the  
25 claim. However, if the plan requests a copy of the emergency  
26 department report within the 30 working days after receipt of the  
27 electronic claim from the institutional provider, the plan may also  
28 request additional reasonable relevant information within 30  
29 working days of receipt of the emergency department report, at  
30 which time the claim shall be deemed complete. A claim from a  
31 professional provider shall be deemed complete upon submission  
32 of a completed HCFA 1500 or its electronic equivalent or other  
33 format adopted by the National Uniform Billing Committee, and  
34 reasonable relevant information requested by the plan within 30  
35 working days of receipt of the claim. The provider shall provide  
36 the plan reasonable relevant information within 10 working days  
37 of receipt of a written request that is clear and specific regarding  
38 the information sought. If, as a result of reviewing the reasonable  
39 relevant information, the plan requires further information, the  
40 plan shall have an additional 15 working days after receipt of the

1 reasonable relevant information to request the further information,  
2 notwithstanding any time limit to the contrary in this section, at  
3 which time the claim shall be deemed complete.

4 (d) This section shall not apply to claims about which there is  
5 evidence of fraud and misrepresentation, to eligibility  
6 determinations, or in instances where the plan has not been granted  
7 reasonable access to information under the provider's control. A  
8 plan shall specify, in a written notice sent to the provider within  
9 the respective 30 or 45 working days of receipt of the claim, which,  
10 if any, of these exceptions applies to a claim.

11 (e) If a claim or portion thereof is contested on the basis that  
12 the plan has not received information reasonably necessary to  
13 determine payer liability for the claim or portion thereof, both of  
14 the following shall apply:

15 (1) Within three working days of receipt of any of this additional  
16 information, a plan shall provide acknowledgment of receipt of  
17 that information to the claimant. The acknowledgment of receipt  
18 shall be provided via electronic mail unless the claimant has opted  
19 out of the electronic method of transmittal and requested that all  
20 acknowledgments of receipt be transmitted in writing. The  
21 acknowledgment of receipt shall include the tracking number  
22 assigned to the claim pursuant to Section 1370.8.

23 (2) The plan shall have 30 working days or, if the health care  
24 service plan is a health maintenance organization, 45 working days  
25 after receipt of all of the information necessary to determine payer  
26 liability to complete reconsideration of the claim. If a claim, or  
27 portion thereof, undergoing reconsideration is not reimbursed by  
28 delivery to the claimant's address of record within the respective  
29 30 or 45 working days after receipt of all of the information  
30 necessary to determine payer liability, the plan shall pay the greater  
31 of fifteen dollars (\$15) per year or interest at the rate of 15 percent  
32 per annum beginning with the first calendar day after the 30- or  
33 45-working-day period. A health care service plan shall  
34 automatically include the fifteen dollars (\$15) per year or interest  
35 due in the payment made to the claimant, without requiring a  
36 request therefor.

37 (f) The obligation of the plan to comply with this section shall  
38 not be deemed to be waived when the plan requires its medical  
39 groups, independent practice associations, or other contracting  
40 entities to pay claims for covered services. This section shall not

1 be construed to prevent a plan from assigning, by a written contract,  
2 the responsibility to pay interest and late charges pursuant to this  
3 section to medical groups, independent practice associations, or  
4 other entities.

5 (g) A plan shall not delay payment on a claim from a physician  
6 or other provider to await the submission of a claim from a hospital  
7 or other provider, without citing specific rationale as to why the  
8 delay was necessary and providing a monthly update regarding  
9 the status of the claim and the plan's actions to resolve the claim,  
10 to the provider that submitted the claim.

11 (h) A health care service plan shall not request or require that  
12 a provider waive its rights pursuant to this section.

13 (i) This section shall not apply to capitated payments.

14 (j) This section shall apply only to claims for services rendered  
15 to a patient who was provided emergency services and care as  
16 defined in Section 1317.1 in the United States on or after  
17 September 1, 1999.

18 (k) This section shall not be construed to affect the rights or  
19 obligations of any person pursuant to Section 1371.

20 (l) This section shall not be construed to affect a written  
21 agreement, if any, of a provider to submit bills within a specified  
22 time period.

23 SEC. 5. Section 1374.72 of the Health and Safety Code is  
24 amended to read:

25 1374.72. (a) Every health care service plan contract issued,  
26 amended, or renewed on or after July 1, 2000, that provides  
27 hospital, medical, or surgical coverage shall provide coverage for  
28 the diagnosis and medically necessary treatment of severe mental  
29 illnesses of a person of any age, and of serious emotional  
30 disturbances of a child, as specified in subdivisions (d) and (e),  
31 under the same terms and conditions applied to other medical  
32 conditions as specified in subdivision (c).

33 (b) These benefits shall include the following:

34 (1) Outpatient services.

35 (2) Inpatient hospital services.

36 (3) Partial hospital services.

37 (4) Prescription drugs, if the plan contract includes coverage  
38 for prescription drugs.

39 (c) ~~Any~~ *The terms and conditions applied to the benefits*  
40 *required by this section, that shall be applied equally to all benefits*

1 *under the plan contract, include, but are not limited to, any form*  
2 *of treatment limitation or other action by a plan that may limit the*  
3 *receipt of benefits required by this section shall be applied under*  
4 *the same terms and conditions that apply to other benefits under*  
5 *the plan contract. These this section. These treatment limitations*  
6 *or actions include, but are not limited to, the use of any of the*  
7 *following:*

- 8 (1) Maximum lifetime benefits.
- 9 (2) Copayments.
- 10 (3) Individual and family deductibles.
- 11 (d) For the purposes of this section, “severe mental illnesses”  
12 shall include:

- 13 (1) Schizophrenia.
- 14 (2) Schizoaffective disorder.
- 15 (3) Bipolar disorder (manic-depressive illness).
- 16 (4) Major depressive disorders.
- 17 (5) Panic disorder.
- 18 (6) Obsessive-compulsive disorder.
- 19 (7) Pervasive developmental disorder or autism.
- 20 (8) Anorexia nervosa.
- 21 (9) Bulimia nervosa.

22 (e) For the purposes of this section, a child suffering from,  
23 “serious emotional disturbances of a child” shall be defined as a  
24 child who (1) has one or more mental disorders as identified in the  
25 most recent edition of the Diagnostic and Statistical Manual of  
26 Mental Disorders, other than a primary substance use disorder or  
27 developmental disorder, that result in behavior inappropriate to  
28 the child’s age according to expected developmental norms, and  
29 (2) who meets the criteria in paragraph (2) of subdivision (a) of  
30 Section 5600.3 of the Welfare and Institutions Code.

31 (f) This section shall not apply to contracts entered into pursuant  
32 to Chapter 7 (commencing with Section 14000) or Chapter 8  
33 (commencing with Section 14200) of Division 9 of Part 3 of the  
34 Welfare and Institutions Code, between the State Department of  
35 Health Services and a health care service plan for enrolled  
36 Medi-Cal beneficiaries.

37 (g) (1) For the purpose of compliance with this section, a plan  
38 may provide coverage for all or part of the mental health services  
39 required by this section through a separate specialized health care

1 service plan or mental health plan, and shall not be required to  
2 obtain an additional or specialized license for this purpose.

3 (2) A plan shall provide the mental health coverage required by  
4 this section in its entire service area and in emergency situations  
5 as may be required by applicable laws and regulations. For  
6 purposes of this section, health care service plan contracts that  
7 provide benefits to enrollees through preferred provider contracting  
8 arrangements are not precluded from requiring enrollees who reside  
9 or work in geographic areas served by specialized health care  
10 service plans or mental health plans to secure all or part of their  
11 mental health services within those geographic areas served by  
12 specialized health care service plans or mental health plans.

13 (3) Notwithstanding any other provision of law, in the provision  
14 of benefits required by this section, a health care service plan may  
15 utilize case management, network providers, utilization review  
16 techniques, prior authorization, copayments, or other cost sharing,  
17 subject to the limitation imposed under subdivision (c).

18 (h) Nothing in this section shall be construed to deny or restrict  
19 in any way the department's authority to ensure plan compliance  
20 with this chapter when a plan provides coverage for prescription  
21 drugs.

22 SEC. 6. Section 10123.125 is added to the Insurance Code, to  
23 read:

24 10123.125. Upon receipt of a claim, a health insurer shall assign  
25 a tracking number to the claim and shall provide acknowledgment  
26 of receipt of the claim to both the provider and the insured. The  
27 acknowledgment of receipt shall identify the assigned tracking  
28 number and shall be provided via electronic mail, unless the  
29 provider or insured has opted out of the electronic method of  
30 transmittal and requested that all acknowledgments of receipt be  
31 transmitted in writing. In the case of an orally submitted claim,  
32 the acknowledgment of receipt shall also be provided orally to the  
33 submitting provider or insured. All communications regarding the  
34 claim shall reference the tracking number assigned pursuant to  
35 this section.

36 SEC. 7. Section 10123.13 of the Insurance Code is amended  
37 to read:

38 10123.13. (a) Every insurer issuing group or individual policies  
39 of health insurance that covers hospital, medical, or surgical  
40 expenses, including those telemedicine services covered by the

1 insurer as defined in subdivision (a) of Section 2290.5 of the  
2 Business and Professions Code, shall reimburse claims or any  
3 portion of any claim, whether in state or out of state, for those  
4 expenses as soon as practical, but no later than 30 working days  
5 after receipt of the claim by the insurer unless the claim or portion  
6 thereof is contested by the insurer, in which case the claimant shall  
7 be notified, in writing, that the claim is contested or denied, within  
8 30 working days after receipt of the claim by the insurer. The  
9 notice that a claim is being contested or denied shall identify the  
10 portion of the claim that is contested or denied and the specific  
11 reasons, including for each reason the factual and legal basis known  
12 at that time by the insurer, for contesting or denying the claim. If  
13 the reason is based solely on facts or solely on law, the insurer is  
14 required to provide only the factual or the legal basis for its reason  
15 for contesting or denying the claim. The insurer shall provide a  
16 copy of the notice to each insured who received services pursuant  
17 to the claim that was contested or denied and to the insured's health  
18 care provider that provided the services at issue. The notice shall  
19 advise the provider who submitted the claim on behalf of the  
20 insured or pursuant to a contract for alternative rates of payment  
21 and the insured that either may seek review by the department of  
22 a claim that the insurer contested or denied, and the notice shall  
23 include the address, Internet Web site address, and telephone  
24 number of the unit within the department that performs this review  
25 function. The notice to the provider may be included on either the  
26 explanation of benefits or remittance advice and shall also contain  
27 a statement advising the provider of its right to enter into the  
28 dispute resolution process described in Section 10123.137. The  
29 notice to the insured may also be included on the explanation of  
30 benefits.

31 (b) If an uncontested claim is not reimbursed by delivery to the  
32 claimant's address of record within 30 working days after receipt,  
33 interest shall accrue and shall be payable at the rate of 10 percent  
34 per annum beginning with the first calendar day after the  
35 ~~30-working-day~~ 30-working-day period.

36 (c) For purposes of this section, a claim, or portion thereof, is  
37 reasonably contested when the insurer has not received a completed  
38 claim and all information necessary to determine payer liability  
39 for the claim, or has not been granted reasonable access to  
40 information concerning provider services. Information necessary

1 to determine liability for the claims includes, but is not limited to,  
2 reports of investigations concerning fraud and misrepresentation,  
3 and necessary consents, releases, and assignments, a claim on  
4 appeal, or other information necessary for the insurer to determine  
5 the medical necessity for the health care services provided to the  
6 claimant.

7 (d) If a claim or portion thereof is contested on the basis that  
8 the insurer has not received information reasonably necessary to  
9 determine payer liability for the claim or portion thereof, both of  
10 the following shall apply:

11 (1) Within three working days of receipt of any of this additional  
12 information, the insurer shall provide acknowledgment of receipt  
13 of that information to the claimant. The acknowledgment of receipt  
14 shall be provided via electronic mail unless the claimant has opted  
15 out of the electronic method of transmittal and requested that all  
16 acknowledgments of receipt be transmitted in writing. The  
17 acknowledgment of receipt shall include the tracking number  
18 assigned to the claim pursuant to Section 10123.125.

19 (2) If the insurer has received all of the information necessary  
20 to determine payer liability for a contested claim and has not  
21 reimbursed a claim determined to be payable within 30 working  
22 days of receipt of that information, interest shall accrue and be  
23 payable at a rate of 10 percent per annum beginning with the first  
24 calendar day after the ~~30-working-day~~ 30-working-day period.

25 (e) The obligation of the insurer to comply with this section  
26 shall not be deemed to be waived when the insurer requires its  
27 contracting entities to pay claims for covered services.

28 SEC. 8. Section 10123.135 of the Insurance Code is amended  
29 to read:

30 10123.135. (a) Every health insurer, or an entity with which  
31 it contracts for services that include utilization review or utilization  
32 management functions, that prospectively, retrospectively, or  
33 concurrently reviews and approves, modifies, delays, or denies,  
34 based in whole or in part on medical necessity, requests by  
35 providers prior to, retrospectively, or concurrent with the provision  
36 of health care services to insureds, or that delegates these functions  
37 to medical groups or independent practice associations or to other  
38 contracting providers, shall comply with this section.

39 (b) (1) A health insurer that is subject to this section, or any  
40 entity with which an insurer contracts for services that include

1 utilization review or utilization management functions, shall have  
2 written policies and procedures establishing the process by which  
3 the insurer prospectively, retrospectively, or concurrently reviews  
4 and approves, modifies, delays, or denies, based in whole or in  
5 part on medical necessity, requests by providers of health care  
6 services for insureds. These policies and procedures shall ensure  
7 that decisions based on the medical necessity of proposed health  
8 care services are consistent with criteria or guidelines that are  
9 supported by clinical principles and processes. These criteria and  
10 guidelines shall be developed pursuant to subdivision (f). These  
11 policies and procedures, and a description of the process by which  
12 an insurer, or an entity with which an insurer contracts for services  
13 that include utilization review or utilization management functions,  
14 reviews and approves, modifies, delays, or denies requests by  
15 providers prior to, retrospectively, or concurrent with the provision  
16 of health care services to insureds, shall be filed with the  
17 commissioner, and shall be disclosed by the insurer to insureds  
18 and providers upon request, and by the insurer to the public upon  
19 request.

20 (2) Upon receipt of a request by a provider prior to,  
21 retrospectively, or concurrent with the provision of health care  
22 services to an insured, a health insurer, or the entity with which  
23 the insurer contracts for services that include utilization review or  
24 utilization management functions, shall assign a tracking number  
25 to the request and shall provide acknowledgment of receipt of the  
26 request to both the provider and the insured. The acknowledgment  
27 of receipt shall identify the assigned tracking number and shall be  
28 provided via electronic mail, unless the provider or insured has  
29 opted out of the electronic method of transmittal and requested  
30 that all acknowledgments of receipt be transmitted in writing. In  
31 the case of an orally submitted request, the acknowledgment of  
32 receipt shall also be provided orally to the submitting provider.  
33 All communications regarding the request, including, but not  
34 limited to, the communications or responses identified in  
35 subdivision (h), shall reference the tracking number assigned  
36 pursuant to this paragraph.

37 (c) If the number of insureds covered under health benefit plans  
38 in this state that are issued by an insurer subject to this section  
39 constitute at least 50 percent of the number of insureds covered  
40 under health benefit plans issued nationwide by that insurer, the

1 insurer shall employ or designate a medical director who holds an  
2 unrestricted license to practice medicine in this state issued  
3 pursuant to Section 2050 of the Business and Professions Code or  
4 the Osteopathic Initiative Act, or the insurer may employ a clinical  
5 director licensed in California whose scope of practice under  
6 California law includes the right to independently perform all those  
7 services covered by the insurer. The medical director or clinical  
8 director shall ensure that the process by which the insurer reviews  
9 and approves, modifies, delays, or denies, based in whole or in  
10 part on medical necessity, requests by providers prior to,  
11 retrospectively, or concurrent with the provision of health care  
12 services to insureds, complies with the requirements of this section.  
13 Nothing in this subdivision shall be construed as restricting the  
14 existing authority of the Medical Board of California.

15 (d) If an insurer subject to this section, or individuals under  
16 contract to the insurer to review requests by providers, approve  
17 the provider's request pursuant to subdivision (b), the decision  
18 shall be communicated to the provider pursuant to subdivision (h).

19 (e) An individual, other than a licensed physician or a licensed  
20 health care professional who is competent to evaluate the specific  
21 clinical issues involved in the health care services requested by  
22 the provider, may not deny or modify requests for authorization  
23 of health care services for an insured for reasons of medical  
24 necessity. The decision of the physician or other health care  
25 provider shall be communicated to the provider and the insured  
26 pursuant to subdivision (h).

27 (f) (1) An insurer shall disclose, or provide for the disclosure,  
28 to the commissioner and to network providers, the process the  
29 insurer, its contracting provider groups, or any entity with which  
30 it contracts for services that include utilization review or utilization  
31 management functions, uses to authorize, delay, modify, or deny  
32 health care services under the benefits provided by the insurance  
33 contract, including coverage for subacute care, transitional inpatient  
34 care, or care provided in skilled nursing facilities. An insurer shall  
35 also disclose those processes to policyholders or persons designated  
36 by a policyholder, or to any other person or organization, upon  
37 request.

38 (2) The criteria or guidelines used by an insurer, or an entity  
39 with which an insurer contracts for utilization review or utilization  
40 management functions, to determine whether to authorize, modify,

1 delay, or deny health care services, shall comply with all of the  
2 following:

3 (A) Be developed with involvement from actively practicing  
4 health care providers.

5 (B) Be consistent with sound clinical principles and processes.

6 (C) Be evaluated, and updated if necessary, at least annually.

7 (D) If used as the basis of a decision to modify, delay, or deny  
8 services in a specified case under review, be disclosed to the  
9 provider and the policyholder in that specified case.

10 (E) Be available to the public upon request. An insurer shall  
11 only be required to disclose the criteria or guidelines for the  
12 specific procedures or conditions requested. An insurer may charge  
13 reasonable fees to cover administrative expenses related to  
14 disclosing criteria or guidelines pursuant to this paragraph that are  
15 limited to copying and postage costs. The insurer may also make  
16 the criteria or guidelines available through electronic  
17 communication means.

18 (3) The disclosure required by subparagraph (E) of paragraph  
19 (2) shall be accompanied by the following notice: “The materials  
20 provided to you are guidelines used by this insurer to authorize,  
21 modify, or deny health care benefits for persons with similar  
22 illnesses or conditions. Specific care and treatment may vary  
23 depending on individual need and the benefits covered under your  
24 insurance contract.”

25 (g) If an insurer subject to this section requests medical  
26 information from providers in order to determine whether to  
27 approve, modify, or deny requests for authorization, the insurer  
28 shall request only the information reasonably necessary to make  
29 the determination.

30 (h) In determining whether to approve, modify, or deny requests  
31 by providers prior to, retrospectively, or concurrent with the  
32 provision of health care services to insureds, based in whole or in  
33 part on medical necessity, every insurer subject to this section shall  
34 meet the following requirements:

35 (1) Decisions to approve, modify, or deny, based on medical  
36 necessity, requests by providers prior to, or concurrent with, the  
37 provision of health care services to insureds that do not meet the  
38 requirements for the 72-hour review required by paragraph (2),  
39 shall be made in a timely fashion appropriate for the nature of the  
40 insured’s condition, not to exceed five business days from the

1 insurer's receipt of the information reasonably necessary and  
2 requested by the insurer to make the determination. In cases where  
3 the review is retrospective, the decision shall be communicated to  
4 the individual who received services, or to the individual's  
5 designee, within 30 days of the receipt of information that is  
6 reasonably necessary to make this determination, and shall be  
7 communicated to the provider in a manner that is consistent with  
8 current law. For purposes of this section, retrospective reviews  
9 shall be for care rendered on or after January 1, 2000.

10 (2) When the insured's condition is such that the insured faces  
11 an imminent and serious threat to his or her health, including, but  
12 not limited to, the potential loss of life, limb, or other major bodily  
13 function, or the normal timeframe for the decisionmaking process,  
14 as described in paragraph (1), would be detrimental to the insured's  
15 life or health or could jeopardize the insured's ability to regain  
16 maximum function, decisions to approve, modify, or deny requests  
17 by providers prior to, or concurrent with, the provision of health  
18 care services to insureds shall be made in a timely fashion,  
19 appropriate for the nature of the insured's condition, but not to  
20 exceed 72 hours after the insurer's receipt of the information  
21 reasonably necessary and requested by the insurer to make the  
22 determination.

23 (3) Decisions to approve, modify, or deny requests by providers  
24 for authorization prior to, or concurrent with, the provision of  
25 health care services to insureds shall be communicated to the  
26 requesting provider within 24 hours of the decision. Except for  
27 concurrent review decisions pertaining to care that is underway,  
28 which shall be communicated to the insured's treating provider  
29 within 24 hours, decisions resulting in denial, delay, or  
30 modification of all or part of the requested health care service shall  
31 be communicated to the insured in writing within two business  
32 days of the decision. In the case of concurrent review, care shall  
33 not be discontinued until the insured's treating provider has been  
34 notified of the insurer's decision and a care plan has been agreed  
35 upon by the treating provider that is appropriate for the medical  
36 needs of that patient.

37 (4) Communications regarding decisions to approve requests  
38 by providers prior to, retrospectively, or concurrent with the  
39 provision of health care services to insureds shall specify the  
40 specific health care service approved. Responses regarding

1 decisions to deny, delay, or modify health care services requested  
2 by providers prior to, retrospectively, or concurrent with the  
3 provision of health care services to insureds shall be communicated  
4 to insureds in writing, and to providers initially by telephone or  
5 facsimile, except with regard to decisions rendered retrospectively,  
6 and then in writing, and shall include a clear and concise  
7 explanation of the reasons for the insurer's decision, a description  
8 of the criteria or guidelines used, and the clinical reasons for the  
9 decisions regarding medical necessity. Any written communication  
10 to a physician or other health care provider of a denial, delay, or  
11 modification or a request shall include the name and telephone  
12 number of the health care professional responsible for the denial,  
13 delay, or modification. The telephone number provided shall be a  
14 direct number or an extension, to allow the physician or health  
15 care provider easily to contact the professional responsible for the  
16 denial, delay, or modification. Responses shall also include  
17 information as to how the provider or the insured may file an appeal  
18 with the insurer or seek department review under the unfair  
19 practices provisions of Article 6.5 (commencing with Section 790)  
20 of Chapter 1 of Part 2 of Division 1 and the regulations adopted  
21 thereunder.

22 (5) If the insurer cannot make a decision to approve, modify,  
23 or deny the request for authorization within the timeframes  
24 specified in paragraph (1) or (2) because the insurer is not in receipt  
25 of all of the information reasonably necessary and requested, or  
26 because the insurer requires consultation by an expert reviewer,  
27 or because the insurer has asked that an additional examination or  
28 test be performed upon the insured, provided that the examination  
29 or test is reasonable and consistent with good medical practice,  
30 the insurer shall, immediately upon the expiration of the timeframe  
31 specified in paragraph (1) or (2), or as soon as the insurer becomes  
32 aware that it will not meet the timeframe, whichever occurs first,  
33 notify the provider and the insured, in writing, that the insurer  
34 cannot make a decision to approve, modify, or deny the request  
35 for authorization within the required timeframe, and specify the  
36 information requested but not received, or the expert reviewer to  
37 be consulted, or the additional examinations or tests required. The  
38 insurer shall also notify the provider and enrollee of the anticipated  
39 date on which a decision may be rendered. Upon receipt of all  
40 information reasonably necessary and requested by the insurer,

1 the insurer shall approve, modify, or deny the request for  
2 authorization within the timeframes specified in paragraph (1) or  
3 (2), whichever applies.

4 (6) If the commissioner determines that an insurer has failed to  
5 meet any of the timeframes in this section, or has failed to meet  
6 any other requirement of this section, the commissioner may assess,  
7 by order, administrative penalties for each failure. A proceeding  
8 for the issuance of an order assessing administrative penalties shall  
9 be subject to appropriate notice to, and an opportunity for a hearing  
10 with regard to, the person affected. The administrative penalties  
11 shall not be deemed an exclusive remedy for the commissioner.  
12 These penalties shall be paid to the Insurance Fund.

13 (i) Every insurer subject to this section shall maintain telephone  
14 access for providers to request authorization for health care  
15 services.

16 (j) Nothing in this section shall cause a disability insurer to be  
17 defined as a health care provider for purposes of any provision of  
18 law, including, but not limited to, Section 6146 of the Business  
19 and Professions Code, Sections 3333.1 and 3333.2 of the Civil  
20 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the  
21 Code of Civil Procedure.

22 SEC. 9. Section 10123.147 of the Insurance Code is amended  
23 to read:

24 10123.147. (a) Every insurer issuing group or individual  
25 policies of health insurance that covers hospital, medical, or  
26 surgical expenses, including those telemedicine services covered  
27 by the insurer as defined in subdivision (a) of Section 2290.5 of  
28 the Business and Professions Code, shall reimburse each complete  
29 claim, or portion thereof, whether in state or out of state, as soon  
30 as practical, but no later than 30 working days after receipt of the  
31 complete claim by the insurer. However, an insurer may contest  
32 or deny a claim, or portion thereof, by notifying the claimant, in  
33 writing, that the claim is contested or denied, within 30 working  
34 days after receipt of the complete claim by the insurer. The notice  
35 that a claim, or portion thereof, is contested shall identify the  
36 portion of the claim that is contested, by revenue code, and the  
37 specific information needed from the provider to reconsider the  
38 claim. The notice that a claim, or portion thereof, is denied shall  
39 identify the portion of the claim that is denied, by revenue code,  
40 and the specific reasons for the denial, including the factual and

1 legal basis known at that time by the insurer for each reason. If  
2 the reason is based solely on facts or solely on law, the insurer is  
3 required to provide only the factual or legal basis for its reason to  
4 deny the claim. The insurer shall provide a copy of the notice  
5 required by this subdivision to each insured who received services  
6 pursuant to the claim that was contested or denied and to the  
7 insured's health care provider that provided the services at issue.  
8 The notice required by this subdivision shall include a statement  
9 advising the provider who submitted the claim on behalf of the  
10 insured or pursuant to a contract for alternative rates of payment  
11 and the insured that either may seek review by the department of  
12 a claim that was contested or denied by the insurer and the address,  
13 Internet Web site address, and telephone number of the unit within  
14 the department that performs this review function. The notice to  
15 the provider may be included on either the explanation of benefits  
16 or remittance advice and shall also contain a statement advising  
17 the provider of its right to enter into the dispute resolution process  
18 described in Section 10123.137. An insurer may delay payment  
19 of an uncontested portion of a complete claim for reconsideration  
20 of a contested portion of that claim so long as the insurer pays  
21 those charges specified in subdivision (b).

22 (b) If a complete claim, or portion thereof, that is neither  
23 contested nor denied, is not reimbursed by delivery to the  
24 claimant's address of record within the 30 working days after  
25 receipt, the insurer shall pay the greater of fifteen dollars (\$15)  
26 per year or interest at the rate of 10 percent per annum beginning  
27 with the first calendar day after the 30-working-day period. An  
28 insurer shall automatically include the fifteen dollars (\$15) per  
29 year or interest due in the payment made to the claimant, without  
30 requiring a request therefor.

31 (c) For the purposes of this section, a claim, or portion thereof,  
32 is reasonably contested if the insurer has not received the completed  
33 claim. A paper claim from an institutional provider shall be deemed  
34 complete upon submission of a legible emergency department  
35 report and a completed UB 92 or other format adopted by the  
36 National Uniform Billing Committee, and reasonable relevant  
37 information requested by the insurer within 30 working days of  
38 receipt of the claim. An electronic claim from an institutional  
39 provider shall be deemed complete upon submission of an  
40 electronic equivalent to the UB 92 or other format adopted by the

1 National Uniform Billing Committee, and reasonable relevant  
2 information requested by the insurer within 30 working days of  
3 receipt of the claim. However, if the insurer requests a copy of the  
4 emergency department report within the 30 working days after  
5 receipt of the electronic claim from the institutional provider, the  
6 insurer may also request additional reasonable relevant information  
7 within 30 working days of receipt of the emergency department  
8 report, at which time the claim shall be deemed complete. A claim  
9 from a professional provider shall be deemed complete upon  
10 submission of a completed HCFA 1500 or its electronic equivalent  
11 or other format adopted by the National Uniform Billing  
12 Committee, and reasonable relevant information requested by the  
13 insurer within 30 working days of receipt of the claim. The provider  
14 shall provide the insurer reasonable relevant information within  
15 15 working days of receipt of a written request that is clear and  
16 specific regarding the information sought. If, as a result of  
17 reviewing the reasonable relevant information, the insurer requires  
18 further information, the insurer shall have an additional 15 working  
19 days after receipt of the reasonable relevant information to request  
20 the further information, notwithstanding any time limit to the  
21 contrary in this section, at which time the claim shall be deemed  
22 complete.

23 (d) This section shall not apply to claims about which there is  
24 evidence of fraud and misrepresentation, to eligibility  
25 determinations, or in instances where the plan has not been granted  
26 reasonable access to information under the provider's control. An  
27 insurer shall specify, in a written notice to the provider within 30  
28 working days of receipt of the claim, which, if any, of these  
29 exceptions applies to a claim.

30 (e) If a claim or portion thereof is contested on the basis that  
31 the insurer has not received information reasonably necessary to  
32 determine payer liability for the claim or portion thereof, both of  
33 the following shall apply:

34 (1) Within three working days of receipt of any of this additional  
35 information, the insurer shall provide acknowledgment of receipt  
36 of that information to the claimant. The acknowledgment of receipt  
37 shall be provided via electronic mail unless the claimant has opted  
38 out of the electronic method of transmittal and requested that all  
39 acknowledgments of receipt be transmitted in writing. The

1 acknowledgment of receipt shall include the tracking number  
2 assigned to the claim pursuant to Section 10123.125.

3 (2) The insurer shall have 30 working days after receipt of all  
4 of the information necessary to determine payer liability to  
5 complete reconsideration of the claim. If a claim, or portion thereof,  
6 undergoing reconsideration is not reimbursed by delivery to the  
7 claimant's address of record within the 30 working days after  
8 receipt of all of the information necessary to determine payer  
9 liability, the insurer shall pay the greater of fifteen dollars (\$15)  
10 per year or interest at the rate of 10 percent per annum beginning  
11 with the first calendar day after the 30-working-day period. An  
12 insurer shall automatically include the fifteen dollars (\$15) per  
13 year or interest due in the payment made to the claimant, without  
14 requiring a request therefor.

15 (f) An insurer shall not delay payment on a claim from a  
16 physician or other provider to await the submission of a claim from  
17 a hospital or other provider, without citing specific rationale as to  
18 why the delay was necessary and providing a monthly update  
19 regarding the status of the claim and the insurer's actions to resolve  
20 the claim, to the provider that submitted the claim.

21 (g) An insurer shall not request or require that a provider waive  
22 its rights pursuant to this section.

23 (h) This section shall apply only to claims for services rendered  
24 to a patient who was provided emergency services and care as  
25 defined in Section 1317.1 of the Health and Safety Code in the  
26 United States on or after September 1, 1999.

27 (i) This section shall not be construed to affect the rights or  
28 obligations of any person pursuant to Section 10123.13.

29 (j) This section shall not be construed to affect a written  
30 agreement, if any, of a provider to submit bills within a specified  
31 time period.

32 SEC. 10. Section 10144.5 of the Insurance Code is amended  
33 to read:

34 10144.5. (a) Every policy of health insurance that is issued,  
35 amended, or renewed on or after July 1, 2000, shall provide  
36 coverage for the diagnosis and medically necessary treatment of  
37 severe mental illnesses of a person of any age, and of serious  
38 emotional disturbances of a child, as specified in subdivisions (d)  
39 and (e), under the same terms and conditions applied to other  
40 medical conditions, as specified in subdivision (c).

- 1 (b) These benefits shall include the following:
- 2 (1) Outpatient services.
- 3 (2) Inpatient hospital services.
- 4 (3) Partial hospital services.
- 5 (4) Prescription drugs, if the policy or contract includes coverage
- 6 for prescription drugs.
- 7 (c) ~~Any~~ *The terms and conditions applied to the benefits*
- 8 *required by this section, that shall be applied equally to all benefits*
- 9 *under the health insurance policy, include, but are not limited to,*
- 10 *any form of treatment limitation or other action by an insurer that*
- 11 *may limit the receipt of benefits required by this section shall be*
- 12 ~~applied under the same terms and conditions that apply to other~~
- 13 ~~benefits under the policy.~~ These treatment limitations or actions
- 14 include, but are not limited to, the use of any of the following:
- 15 (1) Maximum lifetime benefits.
- 16 (2) Copayments and coinsurance.
- 17 (3) Individual and family deductibles.
- 18 (d) For the purposes of this section, “severe mental illnesses”
- 19 shall include:
- 20 (1) Schizophrenia.
- 21 (2) Schizoaffective disorder.
- 22 (3) Bipolar disorder (manic-depressive illness).
- 23 (4) Major depressive disorders.
- 24 (5) Panic disorder.
- 25 (6) Obsessive-compulsive disorder.
- 26 (7) Pervasive developmental disorder or autism.
- 27 (8) Anorexia nervosa.
- 28 (9) Bulimia nervosa.
- 29 (e) For the purposes of this section, a child suffering from,
- 30 “serious emotional disturbances of a child” shall be defined as a
- 31 child who (1) has one or more mental disorders as identified in the
- 32 most recent edition of the Diagnostic and Statistical Manual of
- 33 Mental Disorders, other than a primary substance use disorder or
- 34 developmental disorder, that result in behavior inappropriate to
- 35 the child’s age according to expected developmental norms, and
- 36 (2) who meets the criteria in paragraph (2) of subdivision (a) of
- 37 Section 5600.3 of the Welfare and Institutions Code.
- 38 (f) (1) For the purpose of compliance with this section, a health
- 39 insurer may provide coverage for all or part of the mental health
- 40 services required by this section through a separate specialized

1 health care service plan or mental health plan, and shall not be  
2 required to obtain an additional or specialized license for this  
3 purpose.

4 (2) A health insurer shall provide the mental health coverage  
5 required by this section in its entire in-state service area and in  
6 emergency situations as may be required by applicable laws and  
7 regulations. For purposes of this section, health insurers are not  
8 precluded from requiring insureds who reside or work in  
9 geographic areas served by specialized health care service plans  
10 or mental health plans to secure all or part of their mental health  
11 services within those geographic areas served by specialized health  
12 care service plans or mental health plans.

13 (3) Notwithstanding any other provision of law, in the provision  
14 of benefits required by this section, a health insurer may utilize  
15 case management, managed care, or utilization review, subject to  
16 the limitation imposed under subdivision (c).

17 (4) Any action that a health insurer takes to implement this  
18 section, including, but not limited to, contracting with preferred  
19 provider organizations, shall not be deemed to be an action that  
20 would otherwise require licensure as a health care service plan  
21 under the Knox-Keene Health Care Service Plan Act of 1975  
22 (Chapter 2.2 (commencing with Section 1340) of Division 2 of  
23 the Health and Safety ~~Code~~: *Code*).

24 (g) This section shall not apply to accident-only, specified  
25 disease, hospital indemnity, Medicare supplement, dental-only, or  
26 vision-only insurance policies.

27 SEC. 11. No reimbursement is required by this act pursuant to  
28 Section 6 of Article XIII B of the California Constitution because  
29 the only costs that may be incurred by a local agency or school  
30 district will be incurred because this act creates a new crime or  
31 infraction, eliminates a crime or infraction, or changes the penalty  
32 for a crime or infraction, within the meaning of Section 17556 of  
33 the Government Code, or changes the definition of a crime within  
34 the meaning of Section 6 of Article XIII B of the California  
35 Constitution.

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