AMENDED IN SENATE MAY 28, 2010

AMENDED IN SENATE APRIL 26, 2010

SENATE BILL No. 1169

Introduced by Senator Lowenthal

February 18, 2010

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 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.

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:

SECTION 1. Section 1367.01 of the Health and Safety Code is amended to read:

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) (1) 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.

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

(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 requirements for the 72-hour 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 decisionmaking 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 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 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 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 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.

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

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

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

1371. (a) A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, 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 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.

(b) 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. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar ($10) fee.

(c) 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.

(d) 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 both of the following shall apply:

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

(2) 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 all of the information necessary to determine payer liability 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 annum beginning with the first calendar day after the 30- or 45-working-day period.

(e) 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.

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

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, 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 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, both of the following shall apply:

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

(2) 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 all of the information necessary to determine payer liability 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 all of the information necessary to determine payer liability, 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.

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

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

(b) These benefits shall include the following:

(1) Outpatient services.

(2) Inpatient hospital services.

(3) Partial hospital services.

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

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, include, but are not limited to, any form of

treatment limitation or other action by a plan that may limit the receipt of benefits required by this section. These treatment limitations or actions include, but are not limited to, the use of any of the following:

(1) Maximum lifetime benefits.

(2) Copayments.

(3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.

(9) Bulimia nervosa.

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

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

(g) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations

as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

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

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

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

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

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

10123.13. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days

after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, 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 insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons, including for each reason the factual and legal basis known at that time by the insurer, for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

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

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a 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 liability for the claims 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 insurer to determine

the medical necessity for the health care services provided to the claimant.

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

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

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

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

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

10123.135. (a) Every health insurer, or an 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 insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) (1) A health insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer 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 insureds. 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 subdivision (f). These policies and procedures, and a description of the process by which an insurer, or an entity with which an insurer contracts for services that include utilization review or utilization management functions, reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed by the insurer to insureds and providers upon request, and by the insurer to the public upon request.

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

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer 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 the Osteopathic Initiative Act, or the insurer may employ a clinical

director licensed in California whose scope of practice under California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer 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 insureds, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

(d) If an insurer subject to this section, or individuals under contract to the insurer 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) An 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 not deny or modify requests for authorization of health care services for an insured for reasons of medical necessity. The decision of the physician or other health care provider shall be communicated to the provider and the insured pursuant to subdivision (h).

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

(2) The criteria or guidelines used by an insurer, or an entity with which an insurer contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services, shall comply with all of the following:

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

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

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

(D) 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 policyholder in that specified case.

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

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

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer 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 insureds, based in whole or in part on medical necessity, every insurer 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 insureds that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the insured's condition, not to exceed five business days from the insurer's receipt of the information reasonably necessary and requested by the insurer 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 insured's condition is such that the insured 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 decisionmaking process, as described in paragraph (1), would be detrimental to the insured's life or health or could jeopardize the insured'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 insureds shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours after the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds 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 insured'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 insured in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the insured's treating provider has been notified of the insurer's decision and a care plan has been agreed 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 insureds 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 insureds shall be communicated to insureds 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 insurer'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 or 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 provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 and the regulations adopted thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, or because the insurer requires consultation by an expert reviewer, or because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer 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 insurer shall also notify the 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 insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the commissioner determines that an insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the commissioner 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. The administrative penalties shall not be deemed an exclusive remedy for the commissioner. These penalties shall be paid to the Insurance Fund.

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

(j) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the 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.

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

10123.147. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, 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 insurer. However, an insurer 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 complete claim by the insurer. 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, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to

deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer 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 30 working days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer 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 insurer 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 insurer 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 insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the

emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer 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 insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 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 insurer requires further information, the insurer 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. An insurer shall specify, in a written notice to the provider within 30 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 insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, both of the following shall apply:

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

(2) The insurer shall have 30 working days after receipt of all of the information necessary to determine payer liability 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 30 working days after receipt of all of the information necessary to determine payer liability, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer 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) An insurer 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 insurer's actions to resolve the claim, to the provider that submitted the claim.

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

(h) 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 of the Health and Safety Code in the United States on or after September 1, 1999.

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

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

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

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

(b) These benefits shall include the following:

(1) Outpatient services.

(2) Inpatient hospital services.

(3) Partial hospital services.

(4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the health insurance policy, include, but are not limited to, any form of treatment limitation or other action by an insurer that may limit the receipt of benefits required by this section. These treatment limitations or actions include, but are not limited to, the use of any of the following:

(1) Maximum lifetime benefits.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.

(9) Bulimia nervosa.

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

(f) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the mental health coverage required by this section in its entire in-state service area and in

emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

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

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

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

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

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