

AMENDED IN SENATE JUNE 24, 1998

AMENDED IN SENATE MAY 11, 1998

AMENDED IN SENATE MARCH 24, 1998

AMENDED IN ASSEMBLY MAY 27, 1997

AMENDED IN ASSEMBLY MAY 1, 1997

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

ASSEMBLY BILL

No. 1560

Introduced by Assembly Member Scott

March 11, 1997

An act to amend Sections ~~1371.1~~ 1317, 1317.1, 1371, 1371.1, and 1371.4 of the Health and Safety Code, and to amend Sections 10123.13 and 10123.145 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1560, as amended, Scott. Health facilities: health care service plans: emergency care: reimbursement: transfers.

(1) Existing law sets forth requirements of health facilities that maintain and operate emergency departments. These provisions require the health facility to render emergency service and care without first questioning the patient as to the ability to pay for the services or care.

This bill would permit the health facility, if there is no delay or interference with the provision of emergency services and care, to undertake its usual registration process that would

include obtaining specified information from and about a patient.

Existing law regulates the transfer of persons needing emergency services and care from one hospital to another hospital.

This bill would change the conditions under which those transfers would occur. *It would also change the definition of emergency services and care to include the care, treatment, and surgery by a physician necessary to render the emergency medical condition or active labor stabilized.*

Existing

(2) *Existing* law requires a health care service plan to reimburse providers for emergency services and care, except that a health care service plan may deny reimbursement if the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.

~~This bill would revise that exception to authorize a health care service plan to deny reimbursement if the plan enrollee did not require emergency services and care and if a prudent layperson possessing an average knowledge of health and medicine should have known that an emergency medical condition or active labor did not exist. The bill would require a health care service plan also to reimburse a provider for an emergency medical screening —examination,—including ancillary services routinely available to the emergency department examinations provided to enrollees. The bill would change the definition of emergency services and care to include the care, treatment, and surgery by a physician or other appropriate personnel necessary to render the emergency medical condition or active labor stabilized.~~

(3) *Existing* law regulates health care service plans and certain insurers that cover hospital, medical, and surgical expenses, and providers, in the reimbursement of claims of providers. *These provisions provide for notice requirements if the claim is contested, the accrual of interest if uncontested claims are not reimbursed as required, circumstances under which a claim is reasonably contested by the plan or insurer, and procedures for reconsideration of a contested claim.*



This bill would revise these requirements. The bill also would provide that a claim shall be considered completed if it includes designated information.

Since

(4) *Since* willful violation of the law regulating health care service plans is a crime, the bill would impose a state-mandated local program by changing the definition of a crime.

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 1317 of the Health and Safety*
2 *Code is amended to read:*

3 1317. (a) Emergency services and care shall be
4 provided to any person requesting the services or care, or
5 for whom services or care is requested, for any condition
6 in which the person is in danger of loss of life, or serious
7 injury or illness, at any health facility licensed under this
8 chapter that maintains and operates an emergency
9 department to provide emergency services to the public
10 when the health facility has appropriate facilities and
11 qualified personnel available to provide the services or
12 care.

13 (b) In no event shall the provision of emergency
14 services and care be based upon, or affected by, the
15 person's race, ethnicity, religion, national origin,
16 citizenship, age, sex, preexisting medical condition,
17 physical or mental handicap, insurance status, economic
18 status, or ability to pay for medical services, except to the
19 extent that a circumstance such as age, sex, preexisting
20 medical condition, or physical or mental handicap is



1 medically significant to the provision of appropriate
2 medical care to the patient.

3 (c) Neither the health facility, its employees, nor any
4 physician and surgeon, dentist, clinical psychologist, or
5 podiatrist shall be liable in any action arising out of a
6 refusal to render emergency services or care if the refusal
7 is based on the determination, exercising reasonable care,
8 that the person is not suffering from an emergency
9 medical condition, or that the health facility does not
10 have the appropriate facilities or qualified personnel
11 available to render those services.

12 (d) Emergency services and care shall be rendered
13 without first questioning the patient or any other person
14 as to his or her ability to pay therefor. However, ~~the~~ *if*
15 *there is no delay or interference with the provision of*
16 *emergency services and care, a health facility may*
17 *undertake its usual registration process to obtain*
18 *information from or about the patient, including his or*
19 *her identification, address, demographic information,*
20 *health insurance coverage, and primary care provider.*
21 *The* patient or his or her legally responsible relative or
22 guardian shall execute an agreement to pay therefor or
23 otherwise supply insurance or credit information
24 promptly after the services are rendered.

25 (e) If a health facility subject to this chapter does not
26 maintain an emergency department, its employees shall
27 nevertheless exercise reasonable care to determine
28 whether an emergency exists and shall direct the persons
29 seeking emergency care to a nearby facility ~~which~~ *that*
30 can render the needed services, and shall assist the
31 persons seeking emergency care in obtaining the
32 services, including transportation services, in every way
33 reasonable under the circumstances.

34 (f) No act or omission of any rescue team established
35 by any health facility licensed under this chapter, or
36 operated by the federal or state government, a county, or
37 by the Regents of the University of California, done or
38 omitted while attempting to resuscitate any person who
39 is in immediate danger of loss of life shall impose any
40 liability upon the health facility, the officers, members of



1 the staff, nurses, or employees of the health facility,
2 including, but not limited to, the members of the rescue
3 team, or upon the federal or state government or a
4 county, if good faith is exercised.

5 (g) “Rescue team,” as used in this section, means a
6 special group of physicians and surgeons, nurses, and
7 employees of a health facility who have been trained in
8 cardiopulmonary resuscitation and have been designated
9 by the health facility to attempt, in cases of emergency,
10 to resuscitate persons who are in immediate danger of loss
11 of life.

12 (h) This section shall not relieve a health facility of any
13 duty otherwise imposed by law upon the health facility
14 for the designation and training of members of a rescue
15 team or for the provision or maintenance of equipment
16 to be used by a rescue team.

17 *SEC. 2.* Section 1317.1 of the Health and Safety Code
18 is amended to read:

19 1317.1. Unless the context otherwise requires, the
20 following definitions shall control the construction of this
21 article:

22 (a) “Emergency services and care” means medical
23 screening, examination, and evaluation by a physician, or,
24 to the extent permitted by applicable law, by other
25 appropriate personnel under the supervision of a
26 physician, to determine if an emergency medical
27 condition or active labor exists and, if it does, the care,
28 treatment, and surgery by a physician ~~or other~~
29 ~~appropriate personnel necessary to~~ *necessary to* render
30 the emergency medical condition or active labor
31 stabilized, within the capability of the facility. ~~An~~
32 ~~emergency medical screening examination shall include~~
33 ~~ancillary services routinely available to the emergency~~
34 ~~department.~~ *Emergency services and care shall include*
35 *ancillary and consultative services that are required,*
36 *within reasonable medical judgment, for the medical*
37 *screening and stabilization of an enrollee.*

38 (b) “Emergency medical condition” means a medical
39 condition manifesting itself by acute symptoms of
40 sufficient severity (including severe pain) such that the



1 absence of immediate medical attention could result in
2 any of the following:

3 (1) Placing the health of the patient, or, with respect
4 to a pregnant woman, the health of the woman or her
5 unborn child, in serious jeopardy.

6 (2) Serious impairment to bodily functions.

7 (3) Serious dysfunction of any bodily organ or part.

8 (c) “Active labor” means a labor at a time at which
9 either of the following would occur:

10 (1) There is inadequate time to effect safe transfer to
11 another hospital prior to delivery.

12 (2) A transfer may pose a threat to the health and
13 safety of the patient or the unborn child.

14 (d) “Hospital” means all hospitals with an emergency
15 department licensed by the state department.

16 (e) “State department” means the State Department
17 of Health Services.

18 (f) “Medical hazard” means a material deterioration
19 in, or jeopardy to, a patient’s, or, with respect to a
20 pregnant woman, the unborn child’s, medical condition
21 or expected chances for recovery.

22 (g) “Board” means the Medical Board of California.

23 (h) “Within the capability of the facility” means those
24 capabilities that the hospital is required to have as a
25 condition of its emergency medical services permit and
26 services specified on Services Inventory Form 7041 filed
27 by the hospital with the Office of Statewide Health
28 Planning and Development.

29 (i) “Consultation” means the rendering of an opinion,
30 advice, or prescribing treatment by telephone and, when
31 determined to be medically necessary jointly by the
32 emergency and the specialty physicians, includes review
33 of the patient’s medical record, examination, and
34 treatment of the patient in person by a specialty physician
35 who is qualified to give an opinion or provide the
36 necessary treatment in order to render the patient
37 stabilized.

38 (j) “Stabilized” or “stabilization” means either of the
39 following:



1 (1) With respect to an emergency medical condition,
2 that no material deterioration of the condition is likely,
3 within reasonable medical probability, to result from or
4 occur during the transfer of the individual from a facility.

5 (2) With respect to a woman in active labor, that the
6 woman has delivered, including the placenta.

7 ~~SEC. 2.~~

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

10 1371. (a) A health care service plan, including a
11 specialized health care service plan, shall reimburse
12 ~~claims or any portion of any~~ *each claim, or portion*
13 *thereof,* whether in state or out of state, as soon as
14 practical, but no later than 30 working days after receipt
15 of the claim by the health care service plan, or if the
16 health care service plan is a health maintenance
17 organization, 45 working days after receipt of the claim
18 by the health care service plan, ~~unless the claim or~~
19 ~~portion thereof is contested by the plan in which case the~~
20 ~~claimant shall be notified.~~ *However, a plan may contest*
21 *or deny a claim, or portion thereof, by notifying the*
22 *claimant, in writing, that the claim is contested or denied,*
23 *within 30 working days after receipt of the claim by the*
24 *health care service plan, or if the health care service plan*
25 *is a health maintenance organization, 45 working days*
26 *after receipt of the claim by the health care service plan.*
27 *The notice that a claim, or portion thereof, is being*
28 *contested shall identify the portion of the claim that is*
29 *contested and, the specific reasons for contesting the*
30 *claim, and the specific information needed from the*
31 *provider to reconsider the claim. The notice that a claim,*
32 *or portion thereof, is denied shall identify the portion of*
33 *the claim that is denied and the specific reasons for the*
34 *denial. A plan shall not delay payment of an uncontested*
35 *or undenied portion of a claim pending reconsideration*
36 *of a denied or contested portion of that claim.*

37 ~~If an uncontested~~

38 (b) *If a claim, or portion thereof, that is neither*
39 *contested nor denied is not reimbursed by delivery to the*
40 *claimants' address of record within the respective 30 or*



1 45 working days after receipt, interest shall accrue at the
2 rate of *the greater of fifteen dollars (\$15) or 10 percent*
3 *per annum beginning with the first calendar day after the*
4 *30- or 45-working-day period. A health care service plan*
5 *shall automatically include the interest due in the*
6 *payment made to the claimant, without requiring a*
7 *request therefor.*

8 ~~For~~

9 (c) ~~For the purposes of this section, a claim, or portion~~
10 ~~thereof, is reasonably contested where when the plan has~~
11 ~~not received the completed claim and all information~~
12 ~~necessary to determine payer liability for the claim, or has~~
13 ~~not been granted reasonable access to information~~
14 ~~concerning provider services. Information necessary to~~
15 ~~determine payer liability for the claim includes, but is not~~
16 ~~limited to, reports of investigations concerning fraud and~~
17 ~~misrepresentation, and necessary consents, releases, and~~
18 ~~assignments, a claim on appeal, or other information~~
19 ~~necessary for the plan to determine the medical necessity~~
20 ~~for the health care services provided.~~

21 ~~If~~

22 (d) ~~If a claim, or portion thereof, is contested on the~~
23 ~~basis that the plan has not received all information~~
24 ~~reasonably necessary to determine payer liability for the~~
25 ~~claim, or portion thereof and notice has been provided~~
26 ~~pursuant to this section, then the plan shall have 30~~
27 ~~working days or, if the health care service plan is a health~~
28 ~~maintenance organization, 45 working days after receipt~~
29 ~~of this additional information to complete~~
30 ~~reconsideration of the claim. If the claim, or portion~~
31 ~~thereof, undergoing reconsideration is not reimbursed by~~
32 ~~delivery to the claimant's address of record within the~~
33 ~~respective 30 or 45 working days. After receipt of the~~
34 ~~additional information, interest shall accrue at the rate of~~
35 ~~the greater of fifteen dollars (\$15) or 10 percent per~~
36 ~~annum beginning with the first calendar day after the 30-~~
37 ~~or 45-working-day period. A health care service plan shall~~
38 ~~automatically include the interest due in the payment~~
39 ~~made to the claimant, without requiring a request~~
40 ~~therefor.~~



1 ~~The~~

2 (e) *The obligation of the plan to comply with this*
3 *section shall not be deemed to be waived when the plan*
4 *requires its medical groups, independent practice*
5 *associations, or other contracting entities to pay claims for*
6 *covered services.*

7 (f) *A claim shall be considered completed if the claim*
8 *includes all of the following:*

9 (1) *The patient's name, address, and date of birth.*

10 (2) *The enrollee's name.*

11 (3) *The date of service for an outpatient.*

12 (4) *The date of admission and discharge for an*
13 *inpatient.*

14 (5) *The patient's medical record number and*
15 *identification number assigned by the hospital.*

16 (6) *The provider's federal employer identification*
17 *number or social security number.*

18 (7) *The physician identification number for each*
19 *physician rendering services to the patient.*

20 (8) *The revenue codes assigned in accordance with*
21 *the Uniform Billing Manual, as updated.*

22 (9) *The name of the payer.*

23 (10) *The signature of the provider or the provider's*
24 *representative verifying that the services billed for were*
25 *actually provided.*

26 (11) *Any additional information requested from the*
27 *provider by the health care service plan, within 30*
28 *working days after receipt of the initial claim by the*
29 *health care service plan, or if the health care service plan*
30 *is a health maintenance organization, within 45 working*
31 *days after receipt of the initial claim. If a plan requests or*
32 *requires copies of the patient's medical record, the plan*
33 *shall reimburse the provider for those copies at the rates*
34 *specified in Section 123110.*

35 (g) *A plan shall not delay payment of a claim from a*
36 *physician or other provider to await the submission of a*
37 *claim from a hospital.*

38 (h) *For purposes of this section, "claimant" shall mean*
39 *the provider where the provider is reimbursed directly*
40 *by the health care service plan.*



1 (i) A health care service plan shall not request or
2 require that a provider waive its rights pursuant to this
3 section.

4 SEC. 4. Section 1371.1 of the Health and Safety Code
5 is amended to read:

6 1371.1. (a) Whenever a health care service plan,
7 including a specialized health care service plan,
8 determines that in reimbursing a claim for provider
9 services an institutional or professional provider has been
10 overpaid, and then notifies the provider in writing
11 through a separate notice identifying the overpayment
12 and the amount of the overpayment, the provider shall
13 reimburse the health care service plan within 30 working
14 days of receipt by the provider of the notice of
15 overpayment unless the overpayment, or portion
16 thereof, is contested by the provider in which case the
17 health care service plan shall be notified, in writing,
18 within 30 working days. The notice that an overpayment
19 is being contested shall identify the portion of the
20 overpayment that is contested and the specific reasons for
21 contesting the overpayment.

22 ¶

23 (b) If the provider does not make reimbursement for
24 an uncontested overpayment within 30 working days
25 after receipt, interest shall accrue at the rate of 10 percent
26 per annum beginning with the first calendar day after the
27 30-working day period.

28 (c) A health care service plan shall not recoup a
29 suspected overpayment related to one claim by
30 withholding all of or a portion of the payment to be made
31 on a different claim to the provider.

32 SEC. 5. Section 1371.4 of the Health and Safety Code
33 is amended to read:

34 1371.4. (a) A health care service plan, or its
35 contracting medical providers, shall provide 24-hour
36 access for enrollees and providers to obtain timely
37 authorization for medically necessary care, for
38 circumstances where the enrollee has received
39 emergency services and care, and is stabilized, but the
40 treating provider believes that the enrollee may not be



1 transferred or discharged safely. A physician and surgeon
2 shall be available for consultation and for resolving
3 disputed requests for authorizations. A health care
4 service plan that does not require prior authorization as
5 a prerequisite for payment for necessary medical care
6 following stabilization of an emergency medical
7 condition or active labor need not satisfy the
8 requirements of this subdivision.

9 (b) A health care service plan shall reimburse
10 providers for ~~an~~ emergency medical screening
11 ~~examination~~ *examinations* provided to its enrollees. A
12 health care service plan shall also reimburse providers for
13 all emergency services and care provided to its enrollees,
14 until the care results in stabilization of the enrollee,
15 except as provided in subdivision (c). *As long as federal*
16 *or state law requires that emergency services and care be*
17 *provided without first questioning the patient's ability to*
18 *pay, a health care service plan shall not require a provider*
19 *to obtain authorization prior to the provision of*
20 *emergency medical services and care necessary to*
21 *stabilize the enrollee's emergency medical condition.*

22 (c) Payment for emergency services and care may be
23 denied only if the health care service plan reasonably
24 determines that the emergency services and care were
25 never performed. Further, a health care service plan may
26 deny reimbursement to a provider for a medical
27 screening examination in ~~eases in which~~ *(1) a case in*
28 *which* the plan enrollee did not require emergency
29 services and care ~~and~~ *(2) a prudent layperson, possessing*
30 ~~an average knowledge of health and medicine, should~~
31 ~~have known that an emergency medical condition or~~
32 ~~active labor did not exist.~~ *As long as federal or state law*
33 *requires that emergency services and care be provided*
34 *without first questioning the patient's ability to pay, a*
35 *health care service plan shall not require a provider to*
36 ~~obtain authorization prior to the provision of emergency~~
37 ~~services and care.~~ *care and he or she reasonably should*
38 *have known that an emergency did not exist.*

39 (d) If there is a disagreement between the health care
40 service plan and the provider regarding the need for



1 necessary medical care, *following stabilization of the*
2 *enrollee*, the plan shall assume responsibility for the care
3 of the patient either by having ~~its medical personnel~~
4 *medical personnel contracting with the plan* personally
5 take over the care of the patient within a reasonable
6 amount of time after the disagreement, or by having a
7 general acute care hospital and a physician and surgeon,
8 both under contract with the plan, agree to accept the
9 transfer of the patient as provided in Section 1317.2,
10 Section 1317.2a, or other pertinent statute. However, this
11 requirement shall not apply to necessary medical care
12 provided in hospitals outside the service area of the health
13 care service plan. If the health care service plan fails to
14 satisfy the requirements of this subdivision, further
15 necessary care shall be deemed to have been authorized
16 by the plan. Payment for this care may not be denied.

17 (e) A health care service plan may delegate the
18 responsibilities enumerated in this section to the plan's
19 contracting medical providers.

20 (f) Subdivisions (b), (c), (d), and (g) shall not apply
21 with respect to ~~either a provider with which the health~~
22 ~~care service plan has a contract that includes the~~
23 ~~provision of emergency services and care and necessary~~
24 ~~medical care or~~ a health care service plan that has
25 3,500,000 enrollees and maintains a prior authorization
26 system ~~which~~ *that* includes the availability by telephone
27 within 30 minutes of an emergency physician who is on
28 duty at an emergency department of a general acute care
29 hospital.

30 (g) The Department of Corporations shall adopt by
31 July 1, 1995, on an emergency basis, regulations governing
32 instances when an enrollee requires medical care
33 following stabilization of an emergency condition,
34 including appropriate timeframes for a health care
35 service plan to respond to requests for treatment
36 authorization.

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



1 (i) The definitions set forth in Section 1317.1 shall
2 control the construction of this section.

3 ~~SEC. 3.~~

4 *SEC. 6. Section 10123.13 of the Insurance Code is*
5 *amended to read:*

6 10123.13. (a) Every insurer issuing group or
7 individual policies of disability insurance that covers
8 hospital, medical, or surgical expenses, including those
9 telemedicine services covered by the insurer as defined
10 in subdivision (a) of Section 2290.5 of the Business and
11 Professions Code, shall reimburse ~~claims or any portion of~~
12 ~~any~~ *each claim, or portion thereof*, whether in state or out
13 of state, for those expenses as soon as practical, but no
14 later than 30 working days after receipt of the claim by
15 the insurer ~~unless the claim or portion thereof is~~
16 ~~contested by the insurer, in which case the claimant shall~~
17 ~~be notified.~~ *However, an insurer may contest or deny a*
18 *claim, or portion thereof, by notifying the claimant, in*
19 *writing, that the claim is contested or denied, within 30*
20 *working days after receipt of the claim by the insurer.*
21 *The notice that a claim, or portion thereof, is being*
22 *contested shall identify the portion of the claim that is*
23 *contested and, the specific reasons for contesting the*
24 *claim, and the specific information needed from the*
25 *provider to reconsider the claim. The notice that a claim,*
26 *or portion thereof, is denied shall identify the portion of*
27 *the claim that is denied and the specific reasons for the*
28 *denial. An insurer shall not delay payment of an*
29 *uncontested or undenied portion of a claim pending*
30 *reconsideration of a denied or contested portion of that*
31 *claim.*

32 ~~If an uncontested~~

33 (b) *If a claim, or portion thereof, that is neither*
34 *contested or denied is not reimbursed by delivery to the*
35 *claimant's address of record within 30 working days after*
36 *receipt, interest shall accrue at the rate of the greater of*
37 *fifteen dollars (\$15) or 10 percent per annum beginning*
38 *with the first calendar day after the 30-working-day*
39 *period. An insurer shall automatically include the interest*



1 *due in the payment made to the claimant, without*
2 *requiring a request therefor.*

3 ~~For~~

4 (c) ~~For purposes of this section, a claim, or portion~~
5 ~~thereof, is reasonably contested when the insurer has not~~
6 ~~received a completed claim and all information necessary~~
7 ~~to determine payer liability for the claim, or has not been~~
8 ~~granted reasonable access to information concerning~~
9 ~~provider services. Information necessary to determine~~
10 ~~liability for the claims includes, but is not limited to,~~
11 ~~reports of investigations concerning fraud and~~
12 ~~misrepresentation, and necessary consents, releases, and~~
13 ~~assignments, a claim on appeal, or other information~~
14 ~~necessary for the insurer to determine the medical~~
15 ~~necessity for the health care services provided to the~~
16 ~~claimant.~~

17 (d) *If a claim, or portion thereof, is contested on the*
18 *basis that the insurer has not received information*
19 *reasonably necessary to determine liability for the claim,*
20 *or portion thereof, then the insurer shall have 30 working*
21 *days after the receipt of this additional information to*
22 *complete reconsideration of the claim. If a claim, or*
23 *portion thereof, undergoing reconsideration is not*
24 *reimbursed by delivery to the claimant's address of*
25 *record within the 30 working days after the receipt of the*
26 *additional information, interest shall accrue at the rate of*
27 *the greater of fifteen dollars (\$15) or 10 percent per*
28 *annum beginning with the first calendar day after the*
29 *30-working-day period. An insurer shall automatically*
30 *include the interest due in the payment made to the*
31 *claimant, without requiring a request therefor.*

32 ~~The~~

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

37 (f) *A claim shall be considered completed if the claim*
38 *includes all of the following:*

39 (1) *The patient's name, address, and date of birth.*

40 (2) *The insured's name.*



- 1 (3) *The date of service for an outpatient.*
2 (4) *The date of admission and discharge for an*
3 *inpatient.*
4 (5) *The patient's medical record number and*
5 *identification number assigned by the hospital.*
6 (6) *The provider's federal employer identification*
7 *number or social security number.*
8 (7) *The physician identification number for each*
9 *physician rendering services to the patient.*
10 (8) *The revenue codes assigned in accordance with*
11 *the Uniform Billing Manual, as updated.*
12 (9) *The name of the payer.*
13 (10) *The signature of the provider or the provider's*
14 *representative verifying that the services billed for were*
15 *actually provided.*
16 (11) *Any additional information requested from the*
17 *provider by the insurer, within 30 working days after*
18 *receipt of the initial claim by the insurer. If an insurer*
19 *requests or requires copies of the patient's medical*
20 *record, the insurer shall reimburse the provider for those*
21 *copies at the rates specified in Section 123110 of the*
22 *Health and Safety Code.*
23 (g) *An insurer shall not delay payment of a claim from*
24 *a physician or other provider to await the submission of*
25 *a claim from a hospital.*
26 (h) *For purposes of this section, "claimant" means the*
27 *provider where the provider is reimbursed directly by*
28 *the insurer.*
29 (i) *An insurer shall not request or require that a*
30 *provider waive its rights pursuant to this section.*
31 *SEC. 7. Section 10123.145 of the Insurance Code is*
32 *amended to read:*
33 10123.145. (a) *Whenever an insurer issuing group or*
34 *individual policies of disability insurance which covers*
35 *hospital, medical, or surgical expenses determines that in*
36 *reimbursing a claim for provider services an institutional*
37 *or professional provider has been overpaid, and then*
38 *notifies the provider in writing through a separate notice*
39 *identifying the overpayment and the amount of the*
40 *overpayment, the provider shall reimburse the insurer*



1 within 30 working days of receipt by the provider of the
2 notice of overpayment unless the overpayment or
3 portion thereof is contested by the provider in which case
4 the insurer shall be notified, in writing, within 30 working
5 days. The notice that an overpayment is being contested
6 shall identify the portion of the overpayment that is
7 contested and the specific reasons for contesting the
8 overpayment.

9 ¶

10 (b) If the provider does not make reimbursement for
11 an uncontested overpayment within 30 working days
12 after receipt, interest shall accrue at the rate of 10 percent
13 per annum beginning with the first calendar day after the
14 30 working day period.

15 (c) An insurer shall not recoup a suspected
16 overpayment related to one claim by withholding all or
17 a portion of the payment to be made on a different claim
18 to the provider.

19 SEC. 8. No reimbursement is required by this act
20 pursuant to Section 6 of Article XIII B of the California
21 Constitution because the only costs that may be incurred
22 by a local agency or school district will be incurred
23 because this act creates a new crime or infraction,
24 eliminates a crime or infraction, or changes the penalty
25 for a crime or infraction, within the meaning of Section
26 17556 of the Government Code, or changes the definition
27 of a crime within the meaning of Section 6 of Article
28 XIII B of the California Constitution.

29 Notwithstanding Section 17580 of the Government
30 Code, unless otherwise specified, the provisions of this act
31 shall become operative on the same date that the act
32 takes effect pursuant to the California Constitution.

