

AMENDED IN SENATE AUGUST 16, 1999

AMENDED IN SENATE JULY 12, 1999

AMENDED IN ASSEMBLY APRIL 27, 1999

AMENDED IN ASSEMBLY APRIL 15, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL

No. 1013

Introduced by Assembly Member Scott

February 25, 1999

An act to amend Sections 1371, 1371.1, 1371.35, and 1387 of, and to add Sections 1367.03 and 1371.36 to, the Health and Safety Code, and to amend Sections 10123.13, 10123.145, and 10123.147 of, and to add Sections 10117.5 and 10123.135 to, the Insurance Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 1013, as amended, Scott. Health care service plans: emergency care.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, a willful violation of any of these provisions is punishable as either a felony or a misdemeanor. Existing law provides that disability insurers are regulated by the Department of Insurance.

This bill would require a health care service plan or certain disability insurers, if the plan or insurer requests or requires

copies of a patient's medical records for use in determining a claims payment for an authorized course of treatment, to reimburse the health care provider for those copies. Since a willful violation of the provisions applicable to health care service plans is a crime, this bill, by changing the definition of a crime, would impose a state-mandated local program.

(2) Existing law regulates health care service plans and certain insurers that cover hospital, medical, and surgical expenses, and providers, in the overpayment and reimbursement of claims of providers.

This bill would revise the procedures for overpayment and reimbursement of claims. The bill would authorize a health care provider or claimant, as defined, to bring an action in a court of competent jurisdiction for an order requiring a health care service plan or an insurer to comply with these procedural provisions and would require the court to order a health care service plan or insurer to pay designated interest and attorneys' fees and costs to any health care provider found to be damaged by the health care service plan's or insurer's noncompliance with these provisions.

(3) The existing provisions regulating the reimbursement of claims prohibit a health care service plan and certain disability insurers from requesting or requiring a provider to waive its rights pursuant to those provisions.

This bill would expand these provisions to prohibit a health care service plan or certain disability insurers from requesting or requiring a provider to waive its rights available under the act with regard to health care service plans and under specified provisions of the Insurance Code with regard to certain disability insurers.

(4) Existing law provides for the imposition of civil penalties for violation of the provisions relating to health care service plans.

This bill would provide that any person who ~~willingly~~ violates these provisions with a frequency that indicates a general business practice, *or commits a knowing violation of these provisions*, shall be liable for a civil penalty of not less than \$10,000 for each violation and not more than \$100,000 for each violation.



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

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

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

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

1 SECTION 1. Section 1367.03 is added to the Health
2 and Safety Code, to read:

3 1367.03. A health care service plan shall not request or
4 require that a health care provider waive its rights
5 available pursuant to this chapter.

6 SEC. 2. Section 1371 of the Health and Safety Code is
7 amended to read:

8 1371. (a) A health care service plan, including a
9 specialized health care service plan, shall reimburse
10 claims or any portion of any claim, whether in state or out
11 of state, as soon as practical, but no later than 30 working
12 days after receipt of the claim by the health care service
13 plan, or if the health care service plan is a health
14 maintenance organization, 45 working days after receipt
15 of the claim by the health care service plan, unless the
16 claim or portion thereof is contested by the plan in which
17 case the claimant shall be notified, in writing, that the
18 claim is contested or denied, within 30 working days after
19 receipt of the claim by the health care service plan, or if
20 the health care service plan is a health maintenance
21 organization, 45 working days after receipt of the claim
22 by the health care service plan. The notice that a claim is
23 being contested shall identify the portion of the claim that
24 is contested and the specific reasons for contesting the
25 claim.

26 (b) If an uncontested claim is not reimbursed by
27 delivery to the claimants' address of record within the
28 respective 30 or 45 working days after receipt, interest
29 shall accrue at the rate of 10 percent per annum



1 beginning with the first calendar day after the 30- or
2 45-working-day period.

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

15 (d) If a claim or portion thereof is contested on the
16 basis that the plan has not received all information
17 necessary to determine payer liability for the claim or
18 portion thereof and notice has been provided pursuant to
19 this section, then the plan shall have 30 working days or,
20 if the health care service plan is a health maintenance
21 organization, 45 working days after receipt of this
22 additional information to complete reconsideration of the
23 claim.

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

29 ~~(f) A health care provider may bring an action in a
30 court of competent jurisdiction for an order requiring a
31 health care service plan to comply with this section. The
32 court shall order a health care service plan to pay twice
33 the interest specified in subdivision (b) and attorney's
34 fees and costs to any health care provider found to be
35 damaged by the health care service plan's
36 noncompliance with this section. The remedies provided
37 by this section are not exclusive and shall be in addition
38 to any other remedies provided by law. This subdivision
39 shall not apply when the parties agree to arbitrate the
40 dispute.~~



1 (f) *The claim processing timeliness and interest*
2 *penalty requirements contained in subdivisions (a) to*
3 *(d), inclusive, shall be deemed to be incorporated into*
4 *every contract between a health care service plan and a*
5 *health care provider that requires the health care service*
6 *plan to pay or reimburse the health care provider for*
7 *claims for covered health care services rendered to the*
8 *plan's enrollees. If a health care provider prevails in a*
9 *legal action seeking to enforce the contractual*
10 *requirements created by this subdivision, the court shall*
11 *order the health care service plan to pay the health care*
12 *provider twice the interest specified in subdivision (b)*
13 *and attorneys' fees and costs. The remedies provided by*
14 *this subdivision are not exclusive and shall be in addition*
15 *to any other remedies provided by law.*

16 (g) *If a health care provider renders emergency*
17 *health care service to an enrollee of a health care service*
18 *plan, and the health care provider has no contract with*
19 *the health care service plan that requires the health care*
20 *service plan to pay or reimburse the health care provider*
21 *for those services, the health care provider may bring an*
22 *action in a court of competent jurisdiction for an order*
23 *requiring the health care service plan to comply with the*
24 *claim processing timeliness and interest penalty*
25 *requirements contained in subdivisions (a) to (d),*
26 *inclusive. If the health care provider prevails in a legal*
27 *action seeking to enforce the requirements created by*
28 *subdivisions (a) to (d), inclusive, the court shall order the*
29 *health care service plan to pay the health care provider*
30 *twice the interest specified in subdivision (b) and*
31 *attorneys' fees and costs. The remedies provided by this*
32 *subdivision are exclusive and shall be in addition to any*
33 *other remedies provided by law.*

34 (h) *Subdivisions (f) and (g) shall not apply to a dispute*
35 *that the parties agree to submit to alternative dispute*
36 *resolution. However, any alternative dispute resolution*
37 *regarding the claim processing timeliness and interest*
38 *penalty requirements contained in this section shall*
39 *commence within 120 days of the date that the request*
40 *was submitted to the health care service plan by the*



1 health care provider to submit the dispute to alternative
2 dispute resolution. If the alternative dispute resolution
3 does not commence within 120 days of the request, the
4 health care provider may bring an action in a court of
5 competent jurisdiction for an order pursuant to
6 subdivision (f) of (g).

7 SEC. 3. Section 1371.1 of the Health and Safety Code
8 is amended to read:

9 1371.1. (a) Whenever a health care service plan,
10 including a specialized health care service plan,
11 determines that in reimbursing a claim for health care
12 services ~~provided by~~, an institutional or professional
13 provider may have been overpaid, the health care service
14 plan shall notify the provider in writing through a
15 separate notice identifying the suspected overpayment
16 and the amount of the suspected overpayment and the
17 specific reasons for believing that an overpayment has
18 been made. The provider shall then reimburse, contest,
19 or deny the suspected overpayment, or portion thereof,
20 by notifying the health care service plan in writing within
21 30 working days of receipt by the provider of the notice
22 of suspected overpayment. The notice that a suspected
23 overpayment is being contested or denied shall identify
24 the portion of the suspected overpayment that is
25 contested or denied, the specific reasons for contesting or
26 denying the suspected overpayment, and the specific
27 relevant information reasonably needed from the health
28 care service plan to render a final decision regarding
29 reimbursement for the suspected overpayment. A
30 provider may delay reimbursement of an uncontested or
31 undenied portion of a suspected overpayment so long as
32 the provider pays those charges specified in subdivision
33 (b) and is subject to penalties in subdivision (f) of Section
34 1371.

35 (b) If the provider does not make reimbursement for
36 an uncontested and undenied overpayment, or portion
37 thereof, within 30 working days after receipt of the notice
38 from the health care service plan, interest shall accrue at
39 the rate of 10 percent per annum beginning with the first
40 calendar day after the 30-working day period after



1 receipt of the notice from the health care service plan. A
2 provider shall automatically include the interest accrued
3 in the reimbursement for an uncontested and undenied
4 overpayment, without requiring a request for this
5 interest by the health care service plan.

6 (c) A health care service plan may recover an
7 overpayment ~~within 30~~ *after 30 working* days of the
8 provider's receipt of the notice of suspected
9 overpayment by withholding all or a portion of the
10 payment to be made on a different claim to the provider
11 when the provider has not ~~responded to the notice of~~
12 *reimbursed the* suspected overpayment, not contested
13 nor denied the overpayment, or the parties have resolved
14 the amount of the overpayment.

15 (d) This section shall not apply to an overpayment by
16 a health care service plan where the plan has paid the
17 health care provider two or more times for the same
18 service or where the plan has erroneously paid one health
19 care provider for services provided by a different health
20 care provider. The plan shall provide evidence of the
21 multiple or erroneous payment to the health care
22 provider to whom the multiple or erroneous payment
23 was made prior to recouping the multiple or erroneous
24 payment.

25 (e) *A health care service plan shall not request or*
26 *require any entity not holding a license under this*
27 *chapter to comply with this section.*

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

30 1371.35. (a) A health care service plan, including a
31 specialized health care service plan, shall reimburse each
32 complete claim, or portion thereof, whether in state or
33 out of state, as soon as practical, but no later than 30
34 working days after receipt of the complete claim by the
35 health care service plan, or if the health care service plan
36 is a health maintenance organization, 45 working days
37 after receipt of the complete claim by the health care
38 service plan. However, a plan may contest or deny a
39 claim, or portion thereof, by notifying the claimant, in
40 writing, that the claim is contested or denied, within 30



1 working days after receipt of the claim by the health care
2 service plan, or if the health care service plan is a health
3 maintenance organization, 45 working days after receipt
4 of the claim by the health care service plan. The notice
5 that a claim, or portion thereof, is contested shall identify
6 the portion of the claim that is contested, by revenue
7 code, and the specific information needed from the
8 provider to reconsider the claim. The notice that a claim,
9 or portion thereof, is denied shall identify the portion of
10 the claim that is denied, by revenue code, and the specific
11 reasons for the denial. A plan may delay payment of an
12 uncontested portion of a complete claim for
13 reconsideration of a contested portion of that claim so
14 long as the plan pays those charges specified in
15 subdivision (b).

16 (b) If a complete claim, or portion thereof, that is
17 neither contested nor denied, is not reimbursed by
18 delivery to the claimant's address of record within the
19 respective 30 or 45 working days after receipt, the plan
20 shall pay the greater of fifteen dollars (\$15) per year or
21 interest at the rate of 10 percent per annum beginning
22 with the first calendar day after the 30- or 45-working-day
23 period. A health care service plan shall automatically
24 include the fifteen dollars (\$15) per year or interest due
25 in the payment made to the claimant, without requiring
26 a request therefor.

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



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

25 (d) This section shall not apply to claims about which
26 there is evidence of fraud and misrepresentation, to
27 eligibility determinations, or in instances where the plan
28 has not been granted reasonable access to information
29 under the provider's control. A plan shall specify, in a
30 written notice sent to the provider within the respective
31 30 or 45 working days of receipt of the claim, which, if any,
32 of these exceptions applies to a claim.

33 (e) If a claim or portion thereof is contested on the
34 basis that the plan has not received information
35 reasonably necessary to determine payer liability for the
36 claim or portion thereof, then the plan shall have 30
37 working days or, if the health care service plan is a health
38 maintenance organization, 45 working days after receipt
39 of this additional information to complete
40 reconsideration of the claim. If a claim, or portion thereof,



1 undergoing reconsideration is not reimbursed by
2 delivery to the claimant's address of record within the
3 respective 30 or 45 working days after receipt of the
4 additional information, the plan shall pay the greater of
5 fifteen dollars (\$15) per year or interest at the rate of 10
6 percent per annum beginning with the first calendar day
7 after the 30- or 45-working-day period. A health care
8 service plan shall automatically include the fifteen dollars
9 (\$15) per year or interest due in the payment made to the
10 claimant, without requiring a request therefor.

11 (f) The obligation of the plan to comply with this
12 section shall not be deemed to be waived when the plan
13 requires its medical groups, independent practice
14 associations, or other contracting entities to pay claims for
15 covered services. This section shall not be construed to
16 prevent a plan from assigning, by a written contract, the
17 responsibility to pay interest and late charges pursuant to
18 this section to medical groups, independent practice
19 associations, or other entities.

20 (g) A plan shall not delay payment on a claim from a
21 physician or other provider to await the submission of a
22 claim from a hospital or other provider, without citing
23 specific rationale as to why the delay was necessary and
24 providing a monthly update regarding the status of the
25 claim and the plan's actions to resolve the claim, to the
26 provider that submitted the claim.

27 (h) This section shall not apply to capitated payments.

28 (i) This section shall apply only to claims for services
29 rendered to a patient who was provided emergency
30 services and care as defined in Section 1317.1 in the
31 United States on or after September 1, 1999.

32 (j) This section shall not be construed to affect the
33 rights or obligations of any person pursuant to Section
34 1371.

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

38 (l) A health care provider may bring an action in a
39 court of competent jurisdiction for an order requiring a
40 health care service plan to comply with this section. The



1 court shall order a health care service plan to pay twice
2 the interest specified in subdivision (b) and attorney's
3 fees and costs to any health care provider found to be
4 damaged by the health care service plan's
5 noncompliance with this section. The remedies provided
6 by this section are not exclusive and shall be in addition
7 to any other remedies provided by law. This subdivision
8 shall not apply when the parties agree to ~~arbitrate the~~
9 ~~dispute~~ *submit the dispute to alternative dispute*
10 *resolution.*

11 SEC. 5. Section 1371.36 is added to the Health and
12 Safety Code, immediately following Section 1371.35, to
13 read:

14 1371.36. (a) If a health care service plan or its agent
15 requests or requires copies of a patient's medical records
16 for use in determining a claims payment for an
17 authorized course of treatment, the health care service
18 plan or its agent shall reimburse the health care provider
19 for those copies at the rates specified in Section 123110.
20 For purposes of this section, "authorized" means that the
21 health care service plan agreed with the provider that the
22 patient needed the course of treatment.

23 ~~(b) A health care service plan shall not require its~~
24 ~~contracting providers or provider groups to obtain on the~~
25 ~~plan's behalf medical records to determine a claims~~
26 ~~payment for an authorized course of treatment.~~

27 *(b) A health care service plan shall not request or*
28 *require any entity not holding a license under this*
29 *chapter to comply with this section.*

30 SEC. 6. Section 1387 of the Health and Safety Code is
31 amended to read:

32 1387. (a) Any person who violates any provision of
33 this chapter, or who violates any rule or order adopted or
34 issued pursuant to this chapter, shall be liable for a civil
35 penalty not to exceed two thousand five hundred dollars
36 (\$2,500) for each violation, which shall be assessed and
37 recovered in a civil action brought in the name of the
38 people of the State of California by the commissioner in
39 any court of competent jurisdiction. However, any
40 person who ~~willingly~~ violates any provision of this chapter



1 with a frequency that indicates a general business
2 practice, *or who commits a knowing violation of this*
3 *chapter*, shall be liable for a civil penalty of not less than
4 ten thousand dollars (\$10,000) for each violation and not
5 more than one hundred thousand dollars (\$100,000) for
6 each violation.

7 (b) As applied to the civil penalties for acts in violation
8 of this chapter, the remedies provided by this section and
9 by other sections of this chapter are not exclusive, and
10 may be sought and employed in any combination to
11 enforce this chapter.

12 (c) No action shall be maintained to enforce any
13 liability created under subdivision (a), unless brought
14 before the expiration of four years after the act or
15 transaction constituting the violation.

16 SEC. 7. Section 10117.5 is added to the Insurance
17 Code, to read:

18 10117.5. An insurer shall not request or require that a
19 health care provider waive its rights available pursuant to
20 this part.

21 SEC. 8. Section 10123.13 of the Insurance Code is
22 amended to read:

23 10123.13. (a) Every insurer issuing group or
24 individual policies of disability insurance that covers
25 hospital, medical, or surgical expenses, including those
26 telemedicine services covered by the insurer as defined
27 in subdivision (a) of Section 2290.5 of the Business and
28 Professions Code, shall reimburse claims or any portion of
29 any claim, whether in state or out of state, for those
30 expenses as soon as practical, but no later than 30 working
31 days after receipt of the claim by the insurer unless the
32 claim or portion thereof is contested by the insurer, in
33 which case the claimant shall be notified, in writing, that
34 the claim is contested or denied, within 30 working days
35 after receipt of the claim by the insurer. The notice that
36 a claim is being contested shall identify the portion of the
37 claim that is contested and the specific reasons for
38 contesting the claim.

39 (b) If an uncontested claim is not reimbursed by
40 delivery to the claimant's address of record within 30



1 working days after receipt, interest shall accrue at the
2 rate of 10 percent per annum beginning with the first
3 calendar day after the 30-working-day period.

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

21 (e) A health care service provider may bring an action
22 in a court of competent jurisdiction for an order requiring
23 ~~a health care service plan~~ *an insurer* to comply with this
24 section. The court shall order ~~a health care service plan~~
25 *an insurer* to pay twice the interest specified in
26 subdivision (b) and attorney's fees and costs to any health
27 care provider found to be damaged by the health care
28 service plan's noncompliance with this section. The
29 remedies provided by this section are not exclusive and
30 shall be in addition to any other remedies provided by
31 law. This subdivision shall not apply when the parties
32 agree to ~~arbitrate the dispute~~ *submit the dispute to*
33 *alternative dispute resolution.*

34 (f) *Subdivision (e) shall not apply to a dispute that the*
35 *parties agree to submit to alternative dispute resolution.*
36 *However, any alternative dispute resolution regarding*
37 *the claim processing timeliness and interest penalty*
38 *requirements contained in this section shall commence*
39 *within 120 days of the date that the request was submitted*
40 *to the insurer by the health care provider to submit the*



1 *dispute to alternative dispute resolution. If the*
2 *alternative dispute resolution does not commence within*
3 *120 days of the request, the health care service provider*
4 *may bring an action in a court of competent jurisdiction*
5 *for an order pursuant to subdivision (e).*

6 SEC. 9. Section 10123.135 is added to the Insurance
7 Code, immediately following Section 10123.13, to read:

8 10123.135. If an insurer issuing group or individual
9 policies of disability insurance that covers hospital,
10 medical, or surgical expenses, or its agent requests or
11 requires copies of a patient's medical records for use in
12 determining a claims payment for an authorized course
13 of treatment, the insurer or its agent shall reimburse the
14 health care provider for those copies at the rates specified
15 in Section 123110 of the Health and Safety Code. For
16 purposes of this section, "authorized" means that the
17 insurer agreed with the provider that the patient needed
18 the course of treatment.

19 SEC. 10. Section 10123.145 of the Insurance Code is
20 amended to read:

21 10123.145. (a) Whenever an insurer issuing group or
22 individual policies of disability insurance that covers
23 hospital, medical, or surgical expenses determines that in
24 reimbursing a claim for health care services ~~provided by~~,
25 an institutional or professional provider may have been
26 overpaid, the insurer shall notify the provider in writing
27 through a separate notice identifying the suspected
28 overpayment and the amount of the suspected
29 overpayment and the specific reasons for believing that
30 an overpayment has been made. The provider shall then
31 reimburse, contest, or deny the suspected overpayment
32 in writing or portion thereof by notifying the insurer
33 within 30 working days of receipt by the provider of the
34 notice of suspected overpayment. The notice that a
35 suspected overpayment is being contested or denied shall
36 identify the portion of the suspected overpayment that is
37 contested or denied, the specific reasons for contesting or
38 denying the suspected overpayment, and the specific
39 relevant information reasonably needed from the insurer
40 to render a final decision regarding reimbursement for



1 the suspected overpayment. A provider may delay
2 reimbursement of an uncontested or undenied portion of
3 a suspected overpayment so long as the provider pays
4 those charges specified in subdivision (b) and is subject
5 to penalties in subdivision (j) of Section 10123.147.

6 (b) If the provider does not make reimbursement for
7 an uncontested and undenied overpayment, or portion
8 thereof, within 30 working days after receipt of the notice
9 from the insurer, interest shall accrue at the rate of 10
10 percent per annum beginning with the first calendar day
11 after the 30-working day period after receipt of the notice
12 from the insurer. A provider shall automatically include
13 the interest accrued in the reimbursement for an
14 uncontested and undenied overpayment, without
15 requiring a request for this interest by the insurer.

16 (c) An insurer may recover an overpayment ~~within 30~~
17 *after 30 working* days of the provider's receipt of the
18 notice of suspected overpayment by withholding all or a
19 portion of the payment to be made on a different claim
20 to the provider when the provider has not ~~responded to~~
21 ~~the notice of~~ *reimbursed the* suspected overpayment, not
22 contested nor denied the overpayment, or the parties
23 have resolved the amount of the overpayment.

24 (d) This section shall not apply to an overpayment by
25 an insurer where the insurer has paid the health care
26 service plan two or more times for the same service or
27 where the insurer has erroneously paid one health care
28 provider for services provided by a different health care
29 provider. The insurer shall provide evidence of the
30 multiple or erroneous payment to the health care
31 provider to whom the multiple or erroneous payment
32 was made prior to recouping the multiple or erroneous
33 payment.

34 SEC. 11. Section 10123.147 of the Insurance Code is
35 amended to read:

36 10123.147. (a) Every insurer issuing group or
37 individual policies of disability insurance that covers
38 hospital, medical, or surgical expenses, including those
39 telemedicine services covered by the insurer as defined
40 in subdivision (a) of Section 2290.5 of the Business and



1 Professions Code, shall reimburse each complete claim,
2 or portion thereof, whether in state or out of state, as soon
3 as practical, but no later than 30 ~~calendar~~ *working* days
4 after receipt of the complete claim by the insurer.
5 However, an insurer may contest or deny a claim, or
6 portion thereof, by notifying the claimant, in writing, that
7 the claim is contested or denied, within 30 ~~calendar~~
8 *working* days after receipt of the complete claim by the
9 insurer. The notice that a claim, or portion thereof, is
10 contested shall identify the portion of the claim that is
11 contested, by revenue code, and the specific information
12 needed from the provider to reconsider the claim. The
13 notice that a claim, or portion thereof, is denied shall
14 identify the portion of the claim that is denied, by
15 revenue code, and the specific reasons for the denial. An
16 insurer may delay payment of an uncontested portion of
17 a complete claim for reconsideration of a contested
18 portion of that claim so long as the insurer pays those
19 charges specified in subdivision (b).

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

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



1 deemed complete upon submission of an electronic
2 equivalent to the UB 92 or other format adopted by the
3 National Uniform Billing Committee, and reasonable
4 relevant information requested by the insurer within 30
5 ~~calendar~~ *working* days of receipt of the claim. However,
6 if the insurer requests a copy of the emergency
7 department report within the 30 ~~calendar~~ *working* days
8 after receipt of the electronic claim from the institutional
9 provider, the insurer may also request additional
10 reasonable relevant information within 30 ~~calendar~~
11 *working* days of receipt of the emergency department
12 report, at which time the claim shall be deemed
13 complete. A claim from a professional provider shall be
14 deemed complete upon submission of a completed
15 HCFA 1500 or its electronic equivalent or other format
16 adopted by the National Uniform Billing Committee, and
17 reasonable relevant information requested by the insurer
18 within 30 ~~calendar~~ *working* days of receipt of the claim.
19 The provider shall provide the insurer reasonable
20 relevant information within 15 ~~calendar~~ *working* days of
21 receipt of a written request that is clear and specific
22 regarding the information sought. If, as a result of
23 reviewing the reasonable relevant information, the
24 insurer requires further information, the insurer shall
25 have an additional 15 ~~calendar~~ *working* days after receipt
26 of the reasonable relevant information to request the
27 further information, notwithstanding any time limit to
28 the contrary in this section, at which time the claim shall
29 be deemed complete.

30 (d) (1) This section shall not apply to claims about
31 which there is evidence of fraud and misrepresentation,
32 to eligibility determinations, or in instances where the
33 insurer has not been granted reasonable access to
34 information under the provider's control. Excluding
35 claims that evidence fraud, an insurer shall specify, in a
36 written notice to the claimant within 30 ~~calendar~~ *working*
37 days of receipt of the claim, which, if any, of these
38 exceptions applies to a claim.

39 (2) Nothing in this section shall be construed to
40 require an insurer to notify a claimant that the claim is



1 being investigated as a suspected fraudulent claim. In the
2 event that the claim is ultimately determined not to be
3 fraudulent and the claimant is not reimbursed within the
4 time period specified in subdivision (a), the disability
5 insurer shall pay the charges specified in subdivision (b)

6 (e) If a claim or portion thereof is contested on the
7 basis that the insurer has not received information
8 reasonably necessary to determine payer liability for the
9 claim or portion thereof, then the insurer shall have 30
10 ~~calendar~~ *working* days after receipt of this additional
11 information to complete reconsideration of the claim. If
12 a claim, or portion thereof, undergoing reconsideration is
13 not reimbursed by delivery to the claimant's address of
14 record within the 30 ~~calendar~~ *working* days after receipt
15 of the additional information, the insurer shall pay the
16 greater of fifteen dollars (\$15) per year or interest at the
17 rate of 10 percent per annum beginning with the first
18 ~~calendar~~ *working* day after the ~~30-calendar-day~~
19 *30-working-day* period. An insurer shall automatically
20 include the fifteen dollars (\$15) per year or interest due
21 in the payment made to the claimant, without requiring
22 a request therefor.

23 (f) An insurer shall not delay payment on a claim from
24 a physician or other provider to await the submission of
25 a claim from a hospital or other provider, without citing
26 specific rationale as to why the delay was necessary and
27 providing a monthly update regarding the status of the
28 claim and the insurer's actions to resolve the claim, to the
29 provider that submitted the claim.

30 (g) This section shall apply only to claims for services
31 rendered to a patient who was provided emergency
32 services and care as defined in Section 1317.1 of the
33 Health and Safety Code in the United States on or after
34 September 1, 1999.

35 (h) This section shall not be construed to affect the
36 rights or obligations of any person pursuant to Section
37 10123.13.

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



1 (j) A claimant may bring an action in a court of
2 competent jurisdiction for an order requiring a disability
3 insurer to comply with this section. If the court finds in
4 favor of the claimant, the court shall order an insurer to
5 pay twice the interest specified in subdivision (b) and
6 attorney’s fees and costs to any claimant damaged by the
7 insurer’s noncompliance with this section.

8 (k) For purposes of this section, “claimant” means any
9 person asserting a right under a disability insurance
10 policy that covers hospital, medical, or surgical benefits as
11 a named insured. “Claimant” shall also include a provider
12 of health care if the insured has delegated the right to file
13 a claim on his or her behalf to the provider of health care.

14 SEC. 12. No reimbursement is required by this act
15 pursuant to Section 6 of Article XIII B of the California
16 Constitution because the only costs that may be incurred
17 by a local agency or school district will be incurred
18 because this act creates a new crime or infraction,
19 eliminates a crime or infraction, or changes the penalty
20 for a crime or infraction, within the meaning of Section
21 17556 of the Government Code, or changes the definition
22 of a crime within the meaning of Section 6 of Article
23 XIII B of the California Constitution.

