

ASSEMBLY BILL

No. 2616

Introduced by Assembly Member Margett

February 25, 2000

An act to amend Sections 10123.13 and 10123.147 of the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 2616, as introduced, Margett. Health insurance: payment of claims.

Existing law regulates providers and certain insurers that cover hospital, medical, and surgical expenses with respect to the reimbursement by insurers 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 set forth additional requirements with respect to maintaining and proving the receipt of claims.

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

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

1 SECTION 1. Section 10123.13 of the Insurance Code
2 is amended to read:
3 10123.13. (a) Every insurer issuing group or
4 individual policies of disability insurance that covers

1 hospital, medical, or surgical expenses, including those
2 telemedicine services covered by the insurer as defined
3 in subdivision (a) of Section 2290.5 of the Business and
4 Professions Code, shall reimburse claims or any portion of
5 any claim, whether in state or out of state, for those
6 expenses as soon as practical, but no later than 30 working
7 days after receipt of the claim by the insurer unless the
8 claim or portion thereof is contested by the insurer, in
9 which case the claimant shall be notified, in writing, that
10 the claim is contested or denied, within 30 working days
11 after receipt of the claim by the insurer. The notice that
12 a claim is being contested shall identify the portion of the
13 claim that is contested and the specific reasons for
14 contesting the claim.

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

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

33 (d) *Each insurer shall maintain a written or electronic*
34 *record of the date of receipt of a claim. The person*
35 *submitting the claim shall be entitled to inspect that*
36 *record on request and to rely on that record or on any*
37 *other admissible evidence as proof of the fact of receipt*
38 *of the claim, including, but not limited to, electronic or*
39 *facsimile confirmation of receipt of a claim.*



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

5 SEC. 2. Section 10123.147 of the Insurance Code is
6 amended to read:

7 10123.147. (a) Every insurer issuing group or
8 individual policies of disability insurance that covers
9 hospital, medical, or surgical expenses, including those
10 telemedicine services covered by the insurer as defined
11 in subdivision (a) of Section 2290.5 of the Business and
12 Professions Code, shall reimburse each complete claim,
13 or portion thereof, whether in state or out of state, as soon
14 as practical, but no later than 30 working days after
15 receipt of the complete claim by the insurer. However,
16 an insurer may contest or deny a claim, or portion thereof,
17 by notifying the claimant, in writing, that the claim is
18 contested or denied, within 30 working days after receipt
19 of the complete claim by the insurer. The notice that a
20 claim, or portion thereof, is contested shall identify the
21 portion of the claim that is contested, by revenue code,
22 and the specific information needed from the provider to
23 reconsider the claim. The notice that a claim, or portion
24 thereof, is denied shall identify the portion of the claim
25 that is denied, by revenue code, and the specific reasons
26 for the denial. An insurer may delay payment of an
27 uncontested portion of a complete claim for
28 reconsideration of a contested portion of that claim so
29 long as the insurer pays those charges specified in
30 subdivision (b).

31 (b) If a complete claim, or portion thereof, that is
32 neither contested nor denied, is not reimbursed by
33 delivery to the claimant's address of record within the 30
34 working days after receipt, the insurer shall pay the
35 greater of fifteen dollars (\$15) per year or interest at the
36 rate of 10 percent per annum beginning with the first
37 calendar day after the 30-working-day period. An insurer
38 shall automatically include the fifteen dollars (\$15) per
39 year or interest due in the payment made to the claimant,
40 without requiring a request therefor.



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

39 (d) This section shall not apply to claims about which
40 there is evidence of fraud and misrepresentation, to



1 eligibility determinations, or in instances where the plan
2 has not been granted reasonable access to information
3 under the provider's control. An insurer shall specify, in
4 a written notice to the provider within 30 working days
5 of receipt of the claim, which, if any, of these exceptions
6 applies to a claim.

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

32 (h) *Each insurer shall maintain a written or electronic*
33 *record of the date of receipt of a claim. The person*
34 *submitting the claim shall be entitled to inspect that*
35 *record on request and to rely on that record or on any*
36 *other admissible evidence as proof of the fact of receipt*
37 *of the claim, including, but not limited to, electronic or*
38 *facsimile confirmation of receipt of a claim.*

39 (i) This section shall apply only to claims for services
40 rendered to a patient who was provided emergency



1 services and care as defined in Section 1317.1 of the
2 Health and Safety Code in the United States on or after
3 September 1, 1999.

4 ~~(i)~~

5 (j) This section shall not be construed to affect the
6 rights or obligations of any person pursuant to Section
7 10123.13.

8 ~~(j)~~

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

