



AB 1455 Provider Claims & Dispute Resolution California Code of Regulations Summary

Purpose of the Regulations: (1) describe what will constitute a “demonstrable and unjust” claims payment pattern, (2) define what constitutes a “complete and accurate claim”, and (3) define what constitutes a “fair, fast and cost-effective” provider dispute resolution process.

[The Health & Safety Code and Insurance Code have established a process whereby providers can submit complaints to the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI) regarding what the provider believes is unfair claims conduct on the part of health plans.]

Applicability: The AB 1455 regulations apply to health care service plans and to capitated providers (IPAs, groups, hospitals, etc.) that are delegated to process their own claims. The requirements also apply if the plan contracts with a “claims processing organization” which pays claims on behalf of the plan. Additionally, by newly enacted provisions in the Insurance Code, many of the same requirements apply to insurers. Regulations apply to entities who lease their networks; i.e., Blue Shield of California leases its provider network to Blue Shield Life & Health Insurance Company [Blue Shield Life]... These regulations do not apply to self-funded business.

Effective Date: The AB 1455 regulations were effective August 25, 2003. However, plans and capitated providers were required to comply as of January 1, 2004. The requirements in the regulations apply to claims (and dispute relating to those claims) for services rendered on or after January 1, 2004. The reporting requirements begin as of 4/30/04 for capitated providers and 5/15/04 for health plans with the first quarterly reports to health plans and to DMHC. Many of the requirements also apply to DOI licensed carriers as of January 1, 2006. Annual reports regarding provider appeals are required to be sent to the Department of Insurance beginning July 1, 2007.

Overview of Regulations: The general summary requirements of the regulations, as they apply to health plans, are grouped into 6 separate categories, primarily by subject matter: (1) what constitutes a complete claim, (2) disclosures to contracting providers, (3) claims receipt, acknowledgment and process requirements, (4) provider appeals process requirements, (5) obligations of capitated providers, and, (6) periodic report requirements. Discussion of enforcement and penalties is not included.

Complete Claim: Current law already imposes certain requirements on health plans and insurers when a “complete” claim is submitted by a provider. The regulations seek to clarify what constitutes a complete claim. Note, it does not mean that the health plan may not need and cannot request additional information to process a claim (e.g., COB information, medical records from another provider, etc). That information can be requested even though a claim is otherwise “complete”:

- Specifies that specific claim form be used (e.g. UB92, CMS Form 1500, etc.) and be completed.
- Adds specific information that must be included by type of provider involved (e.g., current and correct CPT codes and modifiers).
- Confirms that a paper claim from an emergency room is not complete unless it is accompanied by a copy of the ER report. [If submitted electronically, the plan can request a copy of the ER report within 30 days.]
- Confirms that plans can request additional “reasonably relevant” information that is needed to determine liability on the claim and can deny the claim if the information is not received. However, if the claim is denied, the notice must identify what information was requested, the party/entity from whom it was requested and state why the information is necessary for claims adjudication.

Disclosures to Contracted Providers: Each plan and each capitated provider is required to disclose specific information to contracting providers on or before 1/1/04, at the time of contracting or upon request (unless already in the provider’s possession). Can be provided in writing or electronically and can be made available on a website for access. “Required Information” to be disclosed includes:

- Directions for submitting claims manually or electronically (specific information required).
- Instructions on how to confirm receipt of a claim.
- The name of the officer responsible for the provider dispute resolution process.
- Directions for submitting provider appeals (specific information required).
- Directions for submitting batched appeals of similar multiple claims.
- The complete fee schedule.
- Detailed payment policies and rules.
- Any non-standard coding methodologies used to adjudicate claims (must be consistent with CPT and other nationally recognized standards). Must include rules re: global payments, multiple services, modifiers, etc.
- Must give 45 day notice of any changes to the information that must be disclosed, including 45 day advance notice of changes to any fee schedule posted on a website.
- Within 7 days of a request, the plan or capitated provider must provide the DMHC with a sample copy of how the information is made available to the providers and how notice is provided of any modifications.

Claims Requirements: The regulations are perhaps the most detailed in this area and address claims filing deadlines, how claims must be received and acknowledged, forwarding of misfiled claims, claims adjudication procedures, requesting medical records, and overpayments. In a very summary fashion, the regulations do the following:

Claims Filing Deadline: Prohibit claims filing deadlines any shorter than 90 days for contracting providers and 180 days for non-contracting providers.

Further, in COB situations where the plan is secondary, the provider must be given a minimum of 90 days from the date of action by the primary payor to submit a claim (payment, denial, etc. by the primary payor).

If a claim is denied on the grounds that it was not timely filed, then, during the appeal process, the plan must accept and process the claim if the provider demonstrates “good cause” for the delay in the claims submission.

Claims Forwarding: Regulations specifically address requirements for forwarding claims as follows:

- If the claim is incorrectly sent to the plan and is the financial responsibility of a capitated provider then the plan must do the following:
 - If the claim is a claim for emergency services, it must be forwarded by the plan to the capitated provider within 10 working days of receipt.
 - For non-emergency claims, if the billing provider is a contracted provider then the plan can do either within 10 working days of receipt: (i) send the provider a denial notice with instructions as to where to submit the claim, or, (ii) forward the claim to the capitated group. If a non-contracting provider, then the plan must forward the claim to the capitated group within 10 working days.
 - If the claim is incorrectly sent to a capitated provider, then in all instances the capitated provider must forward the claim to the plan within 10 working days of receipt.

[Note, for paper claims, this actually results in a requirement that the plan or capitated provider forward the claim before they are even required to acknowledge it – see below.]

Acknowledgment of Claims:

The regulations generally require that plans and capitated providers either affirmatively acknowledge claims or give the provider easy means by which to determine that claims have been received. The requirements apply to both paper claims and those electronically submitted. Generally the following applies:

- Whether or not the claim is complete, the plan must “identify and acknowledge” receipt of the claim (including the receipt date). That can be done by paper acknowledgement or the plan can provide electronic means (phone, website, etc.) by which the provider can confirm receipt of the claim.
- For paper claims, must acknowledge (or provide means to confirm receipt) within 15 working days.

- For electronic claims, must acknowledge (or provide means to confirm receipt) within 2 working days.
- If EDI claims are submitted through a claims clearing house, the acknowledgment of receipt can be routed back to the clearing house within 2 working days (assumes the provider has a means to confirm receipt through the clearing house).

Claims Adjudication:

For the most part, the regulations restate the current requirements in the Act regarding timely payment of claims, contesting claims, payment of interest, etc. There are some instances in which they “elaborate” or expand on the existing statutory requirements. The following should be noted:

- For each claim that is adjudicated, there must be an “accurate and clear written explanation of the specific reasons” for the action taken.
- Interest on late claims must be paid automatically. If not included with the actual claims payment, then the interest must be paid within 5 days and must include specific written information to identify the claim to which it belongs.
- Sets out what is considered to be a permissible reimbursement amount solely for the purposes of determining if the plan’s claims process is “fair” as follows:
 - Contracting Providers – The agreed-upon rate in the contract.
 - Non-Contracted Providers in PPO & POS Plans – For non-emergency services, the rate set forth in the enrollee’s EOC.
 - Non-Contracted Providers in HMO and Emergency Services – The “reasonable and customary value” for the service as determined by a process that meets some very complex requirements.
- The regulations carve out claims for the non-HMO portion of a POS plan and require that they be processed like PPO claims, within 30 business days of receipt.
- The “date of payment” for a claim is the date the payment is postmarked or electronically transferred (not the system process date). The DMHC and the DOI can audit this indirectly to confirm that checks are not being held by comparing the check print date to the date the check is negotiated by the bank.
- Compliance with the requirements will generally be measured by a 95% compliance standard.

Medical Records Requests:

The regulations recognize that there are instances in which records are needed and that emergency claims more often give rise to a need for medical records. Therefore, the regulations establish the following:

- Plans and capitated providers have the right to request medical records when they are reasonably relevant to determine liability for the claim.
- Requests for information must clearly state what is needed and why.

- For non-emergency claim, medical records can't be requested on more than 3% of claims over any 12 month period. [This number also excludes claims for unauthorized services and fraud investigations.] Must be able to demonstrate this to the DMHC. Note: this is not based on a single provider but all claims from all providers.
- For emergency claims, medical records can't be requested on more than 20% of claims from professional providers over a 12 month period. [Note, for institutional claims, the ER report must accompany the claim in order for it to be complete.]

Overpayment Recoveries:

The regulations restate some existing requirements and impose new requirements relating to recovery of overpayments:

- Limits right to recover to requests made within 365 days of the date of payment (limit does not apply if the overpayment was due to fraud or misrepresentation on the part of the provider).
- Notice of overpayment must be a separate written notice that includes specific information (required by current law).
- Provider has 30 days to contest the overpayment. Any such contest is handled under the provider dispute resolution process.
- Can only offset an overpayment if: (i) the provider does not contest the overpayment, (ii) the provider does not reimburse the plan, and (iii) the provider's contract with the plan specifically authorizes offsets of overpayments.
- If an overpayment is recovered by offset, then notice of the offset must be sent to the provider and must include very specific information.

Note, finally, that contracts with capitated providers must include provisions by which the plan can de-delegate claims payment from the provider if they are not complying with the requirements of the regulations.

Provider Appeals Requirements:

Each plan and each capitated provider must have fast, fair and cost-effective dispute resolution mechanism to process and resolve disputes from providers.

- Applies to all disputes with contracted providers.
- Applies to claims payment disputes with non-contracted providers.
- Can be 2 separate processes, as long as each complies.
- Arbitration doesn't count.
- In order to be a valid appeal, provider must include specific minimum information. [Otherwise can be returned to provider.]
- Notice of the appeal process and certain specified information must be included in all notices to providers regarding payment or denial of a claim.
- Must have written procedures for handling provider disputes.

- Appeals regarding claims must be submitted and processed using the same claim number assigned to the claim.
- Must give provider at least 365 days to submit an appeal.
- Must acknowledge receipt of a provider appeal: within 2 business days for appeals submitted electronically and within 15 working days for appeals submitted in paper form.
- Must resolve appeals in accordance with claims timeliness requirements (30/45 working days) and must send written determination on the appeal within 45 working days.
- If appeal results in additional payment on a claim, must include interest from date of original payment.
- Must maintain all provider appeal records for 5 years.
- Plan and capitated providers must designate an officer to be responsible for the provider appeal process, to review the process, prepare reports, etc.
- Cannot discriminate or retaliate against a provider for filing an appeal.
- Cannot charge provider anything for the appeal, but do not have to reimburse the provider for any cost they incur in pursuing the appeal.
- Annual reports required. [See below.]

Issues to note:

- Regulations do not mandate more than one level of appeal/review.
- Requirements apply to disputes regarding requested overpayment refunds.
- Contracted providers can submit disputes over substantially similar claims in bundled batches as long as sufficient individual claims identification are provided.
- Contracts with capitated providers must include a provision permitting the health plan to take over the provider's appeal process if the capitated provider is not meeting the requirements of the regulations.
- Capitated providers' records of provider appeals must be available to the health plan.
- Providers with disputes over medical necessity or UM have a right to appeal the capitated provider's appeal determination to the health plan.

Capitated Providers (Claims Processing Organizations): The regulations set forth detailed requirements that must be reflected in plans' contracts with capitated providers (or claims processing organizations). Basically, the delegated organizations must be required to comply with all of the same provider claims and appeals requirements. And the providers must do periodic reporting of compliance to the health plan so that the health plan can: (i) monitor compliance, and, (ii) report to the DMHC.

Omitting the specific detail required, the regulations state that the plan's contracts with capitated providers must:

- Obligate the provider to accept and adjudicate claims in accordance with all of the various statutes and regulations.
- Obligate the provider to establish and operate a provider dispute resolution program in compliance with the regulations.
- Obligate the provider to submit the required quarterly reports to the plan.
- Obligate the provider to make its records on claims and provider disputes available to the plan and the DMHC.
- Confirm that providers with disputes regarding medical necessity or UM decisions have a de novo right of appeal to the plan at the completion of the capitated provider's dispute resolution process.

Periodic Reports: The regulations set forth 2 different sets of reporting requirements relating to claims and provider dispute handling; (i) reports that capitated providers (and claims processing organizations) must make to plans, and, (ii) reports that plans must make to the DMHC.

Capitated Provider Reports:

Capitated providers must submit a quarterly report to plans that demonstrates their compliance with the various claims processing and provider appeals requirements. The elements to be disclosed are quite detailed. In addition to the various data elements for claims, the report must include the following:

- A tabulated record of provider disputes received categorized by date of receipt, and including the provide identity, dispute type, disposition and working days to resolution.
- The report must be signed and verified by an officer of the capitated provider.

The report must be sent to the plan within 30 days of the close of each calendar quarter. The first report must be submitted to plans on or before 4/30/04.

Health Plan Reports:

Plans must submit quarterly and annual reports to the DMHC, some of which incorporate the information from the capitated provider quarterly reports. Annual reports regarding provider appeals are required by the DOI.

QUARTERLY REPORTS: Within 60 days of the close of each calendar quarter, plans must file with DMHC a report that:

- Discloses any emerging patterns of claims payment deficiencies.
- Discloses whether any capitated provider (or claims payment organizations) failed to comply with the various claims and provider appeals requirements.

- Discloses any correction action taken in the previous 2 quarters to address any of the above deficiencies.

The first quarterly report is due by May 15, 2003, only 15 days after the due date of the first quarterly reports from capitated providers.

ANNUAL REPORTS: Within 15 days of the close of each calendar year, plans must submit an “Annual Plan Claims Payment & Dispute Resolution Mechanism Report” which:

- Provides information regarding the claims payment compliance status of the plan and each capitated provider.
- Is based on the 12 month period endings as of 9/30 of the prior year.
- Is based on the plan’s own data and the quarterly reports submitted by capitated providers.
- Discloses any patterns of deficiencies and outlines corrective action plans.
- Includes information on the number and types of providers using the dispute resolution procedure.
- Includes a summary of the disposition of provider disputes.
- Identifies any emerging patterns disclosed by the provider appeals and describes action being taken by the plan to improve.

The first annual report pursuant to these new requirements must be filed with the DMHC by 1/15/05. The first annual report pursuant to requirements for health insurers must be provided to the DOI by 7/1/2007.

Unfair Payment Pattern

After laying out all of the above requirements (directly or indirectly) the regulations then contain a list of 14 items of conduct by plans or by capitated providers that will be deemed to constitute a “demonstrable and unjust payment pattern” or an “unfair payment pattern”, thus subjecting the plan to possible sanctions and discipline from the DMHC. [Certain of these are also now stated as affirmative requirements applicable to insurers under the Insurance Code.] Under the regulations, doing any of the following with the stated frequency (a percentage of claims, a number of occurrences over a 3 month period, etc.) would be deemed to be “unfair”:

1. Imposing a claims submission deadline shorter than 90 days.
2. Failing to forward misdirected claims to the right party.
3. Failing to accept a late claim when good cause is shown.
4. Requesting reimbursement for overpayments that doesn’t comply with the notice and offset requirements.
5. Failing to timely acknowledge receipt of claims.
6. Failure to give an accurate and complete explanation on the disposition of a claim (reason for denying, etc.).
7. Requiring, by contract, that the provider submit medical records that are reasonably relevant.

8. Failing to demonstrate, if requested by DMHC, that the plan requested medical records on less than 3% of non-emergency claims.
9. Failing to demonstrate, if requested by DMHC, that the plan requested medical records on less than 20% of emergency claims (not, doesn't include an ER record as required by Section 1371.35).
10. Failure to include necessary contract provision (requiring compliance with AB 1455) in contracts with capitated providers and claims payment organizations.
11. Failure to correctly pay claims and to include interest on claims paid late.
12. Failure to process claims timely.
13. Failure to give contracting providers the "Required Information".
14. Failure to give providers timely notice of any changes to the "Required Information".
15. Requiring a provider to waive rights they have under AB 1455.
16. Failure to give a provider notice of the provider appeal process when a claim is adjudicated.
17. Not giving providers at least 365 days to file an appeal.
18. Failure to timely send an acknowledgment of receipt of a provider appeal.
19. Failure to timely resolve provider appeals.
20. Attempting to rescind or modify an authorization that a provider relied on in good faith.

Compliance with some of these requirements will be demonstrated on an ongoing basis in the periodic reports described above. In other instances, plans (and capitated providers) will demonstrate that upon DMHC or DOI request; either, (1) a request sent to all plans to demonstrate the same thing, or, (2) a special request to Blue Shield as a result of provider complaints sent to DMHC or DOI.

Provider Contract Amendments & Process

Changes have been made to model contracts and to existing contracts by legally required amendment, to: (1) modify existing provisions that conflict with the requirements/prohibitions of the regulations (e.g., timely appeal), and, (2) add new provisions required by law.

In addition, model contract changes and amendments have been made to capitated provider contracts as required by the regulations and to require compliance with the provisions of the regulations.

This information is a summary only and it not intended to represent a complete statement of the provisions of the regulations nor requirements for compliance.