AB1455 Time Limits and Measurements

The purpose of this document is to post all time limits noted in the Claims Processing portion of AB1455 and their applicable unfair payment pattern measurements, and note any other items that include measurements.

Item	Description	Unfair Payment Pattern Measurements
AUTOMATIC PAYMENT OF INTEREST	Interest is due within 5 working days of the payment of the claim without the need for any reminder or request by the provider.	Pay proper interest automatically in 95% of claims owing interest over the course of any 3-month period.
INTEREST LESS THAN $2.00	In the event that the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, the interest for that claim may be paid, along with interest on other such claims, within 10 calendar days of the close of the calendar month in which the claim was paid.	N/A
INPATIENT SERVICE CLAIMS	A payer shall accept separately billable claims for inpatient services on at least a bi-weekly basis. (Cannot require the facility to wait until discharge to submit the full claim.)	N/A
CLAIM FILING DEADLINE	A payer cannot impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service. In the event that the payer is not primary under coordination of benefits, a deadline shall not be imposed for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.	Less than 3 instances over the course of any 3-month period. – Decide favorably for at least 95% of disputes for late claims submission that meet “good cause” explanation.
CLAIM FORWARDING	Claims involving Emergency Services shall be forwarded to the appropriate payer within 10 working days of receipt of the claim. Claims not involving Emergency Services: • If the provider that filed the claim is contracted with the plan’s capitated provider, the plan has 10 working days of the receipt of the claim to: ✓ Send the claimant a notice of denial, with instructions to bill the capitated provider, or ✓ Forward the claim to the appropriate capitated provider • In all other cases, the plan has 10 working days of the receipt of the claim incorrectly sent to the plan to forward the claim to the appropriate payer.	Forward at least 95% of misdirected claims over the course of any 3-month period.

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OVERPAYMENTS	A payer's written request for reimbursement to the provider for an overpayment of a claim must be made within 365 days of the date of payment. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider. If the provider contests the notice of reimbursement of the overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment, shall send a written notice stating the basis upon which the provider believes that the claim was not overpaid. If the provider does not contest the notice of reimbursement, the provider shall reimburse the payer within 30 working days of the receipt by the provider of the notice of overpayment of a claim.	At least 95%: ➢ Send written requests for reimbursement for Overpayments within 365 days; ➢ Clearly explain the basis for the overpayment; ➢ Offset an uncontested notice of overpayment only if the provider fails to reimburse within 30 days and if the provider has a contract agreeing to the offset from current claims submission.
ACKNOWLEDGEMENT OF CLAIMS	Acknowledgement of claims shall be provided within: • 2 working days of the receipt of an electronic claim • 15 working days of the receipt of a paper claim	Acknowledge the receipt of claims at least 95% over the course of any 3-month period.
TIME FOR REIMBURSEMENT	A payer shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim, unless the complete claim or portion thereof is contested or denied. (see contesting or denying claims) If an HMO also maintains a PPO or POS line of business, the plan shall reimburse all claims relating to or arising out of non-HMO lines of business within 30 working days. If a specialized health care service plan contracts with an HMO, they shall reimburse complete claims received for HMO services within 30 working days.	

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TIME FOR CONTESTING OR DENYING CLAIMS	A payer may contest or deny a claim, or portion thereof, by notifying the provider in writing that the claim is contested or denied within 45 working days after the date of receipt of the claim by the payer. If an HMO also maintains a PPO or POS line of business, the plan shall contest or deny claims relating to or arising out of non-HMO lines of business within 30 working days. If a specialized health care service plan contracts with an HMO, they shall contest or deny claims received for HMO services within 30 working days.	At least 95% of the time for the affected claims over the course of any 3-month period.
CONTRACT MODIFICATIONS (to the Information for Contracting Providers and to the Fee Schedules and Other Required Information)	A payer shall provide a minimum of 45 days prior written notice before instituting any changes, amendments or modifications in the disclosures made pursuant to the information in Information for Contracting Providers and Fee Schedules and Other Required Information. (section m)	Less than 3 instances over the course of any three-month period.
REQUIRED REPORTS	Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department of Managed Health Care in a single combined document: • any emerging patterns of claims payment deficiencies • whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95% of its claims (including the payment of interest and penalties), and • the corrective action that has been undertaken over the preceding two quarters. The first report from the plan shall be due within 45 days after the close of the calendar quarter that ends 120 days after the effective date of these regulations. Within 15 days of the close of each calendar year, beginning with the 2004 calendar year, the plan shall submit to the Director, as part of the Annual Plan	

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Item	Description	Unfair Payment Pattern Measurements
	Claims Payment and Dispute Resolution Mechanism Report, information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers.	
OTHER ITEMS WITH MEASUREMENTS		
Item	**Description**	**Unfair Payment Pattern Measurements**
REASONS FOR DENYING, ADJUSTING OR CONTESTING A CLAIM	A payer shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the payer shall provide an accurate and clear written explanation of the specific reasons for the action taken, within the specified time frames.	Provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim at lest 95% of the time over the course of any 3-month period.
REASONABLY RELEVANT INFORMATION – CONTRACT LANGUAGE	A payer shall not include a contract provision with a provider to require the submission of medical records that are not reasonably relevant for the adjudication of a claim.	Less than 3 instances over the course of any 3-month period.
REQUESTS FOR MEDICAL RECORDS (non-emergency and authorized services)	Requests for medical records to determine payer liability must be reasonably necessary.	Less than 3% of claims submitted to a payer by all providers over any 12-month period. (excludes claims involving emergency or unauthorized services, or where payer establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices)
REQUESTS FOR MEDICAL RECORDS (emergency and unauthorized services)	Requests for medical records to determine payer liability must be reasonably necessary.	Less than 20% of emergency services and care professional provider claims submitted over any 12-month period. (excludes claims where the payer demonstrates reasonable grounds for

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		suspecting possible fraud, misrepresentation or unfair billing practices)
MANDATED CONTRACTUAL PROVISIONS	Contracts between a plan and a delegated entity must specify that: • The entity must comply with specific sections of both Health and Safety Code and title 28 which outline the claims adjudication and dispute resolution provisions. (see complete list of these sections on page 14 of the AB1455 Final Text) • The entity will submit a signed and verified Quarterly Claims Report within 30 days of the end of the quarter which will indicate compliance with certain sections of Health and Safety Code and title 28. • The entity will disclose all documents related to Provider Dispute Resolutions (PDR) process and outcomes. • The entity will provide an unconditional right of appeal for medical necessity or Utilization Review related disputes directly to the plan within 60 working days from the delegated entity's Date of Determination. • The plan may assume claims payment responsibility in certain instances where entity fails to fulfill responsibilities of claims payment, corrective action plans (see section 1375.4(b)(4) of H&S Code)	Less than 3 of all contracts contain all required provisions.
PROVISION OF INFORMATION FOR CONTRACTING PROVIDERS, FEE SCHEDULE, AND OTHER REQUIRED INFORMATION (disclosures)	Effective 1/1/04, upon initial contracting with providers and upon written request by a contracted provider, the following information shall be provided: • Directions (including address, phone, fax) for electronic transmission, physical delivery and mailing of claims including the procedure for confirming receipt and phone number for inquiries; • Any specific claim submission requirements such as attachments or supplemental documentation commonly required; and • The identity of the office responsible for PDR including specific address/ directions for submitting single or multiple substantially similar provider disputes as well as timeframes for resolution. Effective 1/1/04, upon initial contracting with providers, annually thereafter and upon written request, the following must be disclosed electronically:	Less than 3 instances over the course of any 3-month period.

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Item	Description	Unfair Payment Pattern Measurements
	• Complete fee schedule including disclosures (see 1300.75.4.1(b) of H&S Code) • Detailed payment rules, policies, non-standard coding methodologies used to adjudicate claims. Examples include clearly explaining the methodology used to arrive as a global payment, clearly stating policies used to modify coding, payment of modifiers, multiple procedures, assistant surgeons, injectables, etc. These rules should be accepted by nationally recognized organizations.	
WAIVER PROHIBITED	A payer shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed by the payer by specific provisions in the Health and Safety Code and title 28 relating to claims processing or payment.	Less than 3 instances over the course of any 3-month period.
NOTICE TO PROVIDER OF DISPUTE RESOLUTION MECHANISM	Whenever a payer contests, adjusts or denies a claim it shall inform the provider of the ability to dispute and include the procedure for obtaining forms, along with mailing address for submission of disputes	At least 95% of the time for the affected claims over the course of any 3-month period.
PROVIDER DISPUTE FILING DEADLINE	Payer shall not impose a deadline for submission of a dispute : For disputes involving claims, billing or contract disputes not less than 365 days from action or in case if inaction, no less than 365 days after the "time" for contesting or denying claims has expired. For disputes related to Demonstrable, Unfair Payment Pattern, time frame for submission shall not be less than 365 days from "payers" most recent action or in the case of inaction, not less than 365 days after the "time" for contesting or denying claims has expired.	Less than 3 affected claims over the course of any 3-month period.
ACKNOWLEDGE RECEIPT OF PROVIDER DISPUTE	In the case of electronic dispute submission, acknowledgement shall be provided within 2 working days from receipt or in the case of paper dispute submission, acknowledgement will be provided within 15 working days. This acknowledgment is to be provided by the office designated to receive provider disputes	At least 95% of the provider disputes received over the course of any 3-month period.
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	A payer shall resolve each provider dispute or amended dispute in a written determination within 45 days of receipt.	At least 95% of the time over the course of any 3-month period.
RESCIND OR MODIFY AN	A payer shall not rescind or modify an authorization for health care services after	Less than 3 instances over the course

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Item	Description	Unfair Payment Pattern Measurements
AUTHORIZATION AFTER SERVICES ARE RENDERED	the provider renders the service in good faith and pursuant to the authorization.	of any 3-month period.