AB1455
Claims Processing
Complete Definitions

Including corresponding section of 1300.71, California Code of Regulations (CCR) title 28

Term	Definition
Automatically Definition: (a) (1) Text: (i) & (j)	"Automatically" means the payment of the interest due to the provider within five (5) working days of the payment of the claim without the need for any reminder or request by the provider. If the interest is not sent in the same envelope as the claim payment, the plan or the plan's capitated provider shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim, and document the specific interest payment made for each claim. 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, a plan or plan's capitated provider that pays claims may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid, provided the plan or the plan's capitated provider includes with the interest payment a statement identifying the specific claims for which the interest is paid, setting forth the method for calculating interest on each claim and documenting the specific interest payment made for each claim.
Complete Claim Definition: (a) (2) Text: (a)(8)(K); (g) & (i)	"Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "reasonably relevant information" as defined in section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and: • For emergency services and care provider claims as defined by section 1371.35(j): ➢ The information specified in section 1371.35(c) of the Health and Safety Code; and ➢ Any state-designated data requirements included in statutes or regulations. • For institutional providers: ➢ The completed UB92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC; ➢ Entries stated as mandatory by NUBC and required by federal statute and regulations; and ➢ Any state-designated data requirements included in statutes or regulations. • For dentists and other professionals providing dental services: ➢ The form and data set approved by the American Dental Association; ➢ Current Dental Terminology (CDT) codes and modifiers; and ➢ Any state-designated data requirements included in statutes or regulations. • For physicians and other professional providers: ➢ The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format; ➢ Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes; ➢ Entries stated as mandatory by NUCC and required by federal statute and regulations; and ➢ Any state-designated data requirements included in statutes or regulations. • For pharmacists: ➢ A universal claim for and data set approved by the National Council on

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	Prescription Drug Programs; and ➢ Any state-designated data requirements included in statues or regulations; • For providers not otherwise specified in these regulations: ➢ A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and ➢ Any state-designated data requirements included in statutes or regulations.
Reimbursement of a Claim Definition: (a) (3) Text: (g) (4); (o)(2)(C)	"Reimbursement of a claim" means: • For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate; • For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care service rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and • (C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.
Date of Contest **Date of Denial or** **Date of Notice** Definition: (a) (4) Text: (b)(1)	"Date of contest, "date of denial" or "date of notice" means the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641. (**§641 Letter received in ordinary course of mail** A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.)
Date of Payment Definition: (a) (5) Text: (b)(1); (b)(5)	"Date of payment" means the date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641. (**§641 Letter received in ordinary course of mail** A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.)

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Date of Receipt (Claims Processing) Definition: (a)(6) Text: (c); (c)(1) & (2); (e)(3)(ii); (g); (h) (See also definition of Date of Receipt under Provider Dispute Resolution)	"Date of receipt" means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim. (**§641 Letter received in ordinary course of mail** A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.)
Date of Service Definition: (a)(7) Text: (b)(1); (d)(3)	"Date of service," for the purposes of evaluating claims submission and payment requirements under these regulations, means: • For outpatient services and all emergency services and care: the date upon which the provider delivered separately billable health care services to the enrollee. • For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a plan and a plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.

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Demonstrable and Unjust Payment Pattern or Unfair Payment Pattern Definition: (a)(8) Text: (s)(3); (s)(6)	A "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern" as set forth in section (s)(4): • (A) The imposition of a Claims Filing Deadline inconsistent with section (b)(1) in three (3) or more claims over the course of any three-month period; • (B) The failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three-month period; • (C) The failure to accept a late claim consistent with section (b)(4) at least 95% of the time for the affected claims over the course of any three-month period; • (D) The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period; • (E) The failure to acknowledge the receipt of at least 95% of claims consistent with section (c) over the course of any three-month period; • (F) The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period; • (G) The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as defined by section (a)(10), for the adjudication of a claim on three (3) or more occasions over the course of any three month period; • (H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payer liability for those claims consistent with the section (a)(2); The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices; • (I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonable necessary to determine payer liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices; • (J) The failure to include the mandated contractual provisions enumerated in section (e) in three (3) or more of its contracts with either claims processing organizations and/or with plan's capitated providers over the course of any three-month period; • (K) The failure to reimburse at least 95% of complete claims with the correct

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	payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period; • (L) The failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period; • (M) The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required by sections (1) and (o) to three (3) or more contracted providers over the course of any three-month period; • (N) The failure to provide three (3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and Other Required Information consistent with section (m) over the course of any three month period; • (O) Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with section (p) on three (3) or more occasions over the course of any three month period; • (P) The failure to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims over the course of any three-month period; • (Q) The imposition of a provider dispute filing deadline inconsistent with section 1300.71.38(d) in three (3) or more affected claims over the course of any three-month period; • (R) The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period; • (S) The failure to comply with the Time Period for Resolution and Written Determination enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period; and • (T) An attempt to rescind or modify an authorization for health care services after the provider renders service in good faith and pursuant to the authorization, inconsistent with section 1371.8, on three (3) or more occasions over the course of any three-month period.
Interest on the Late Payment of Claims DMHC's "AB 1455" regulations	(1) Late payment on a complete **claim for emergency services** and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. (2) Late payments on **all other complete claims** shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.
Health Maintenance Organization (HMO) Definition: (a)(9) Text: (g)(1); (h)(1)	"Health Maintenance Organization" or "HMO" means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).
Reasonably Relevant Information Definition: (a)(10) Text: (a)(2); (a)(8)(G); (d)(2); (k)	"Reasonably relevant information" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

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Information Necessary to Determine Payer Liability Definition: (a)(11) Text: (a)(2); (h)(3)	“Information Necessary to Determine Payer Liability” means the minimum amount of material information in the possession of third parties related to a provider’s billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan’s or the plan’s capitated provider’s liability, if any, and to comply with any governmental information requirements.
Plan	“Plan” for the purposes of this section means a licensed health care service plan and any contracted claims processing organizations.
Working Days Definition: (a)(13) Text: (a)(1); (b)(2)(A): (b)(3); (c)(1) & (2); (d)(5); (e)(5); (g); (g)(1) & (2); (h); (h)(1) & (2)	“Working days” means Monday through Friday, excluding recognized federal holidays.