§ 1371. Reimbursement of claims; Contested claims

(a)(1) A health care service plan, including a specialized health care service plan, shall reimburse claims or a portion of a claim, whether in state or out of state, as soon as practicable, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

(2) If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all

interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. A plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.

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

(4) If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period.

(b) Notwithstanding any other law, a specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to investigate suspected fraud and to recover overpayments made as a result of fraud only if the specialized health care service plan complies with this subdivision.

(1) A specialized health care service plan's statistically reliable method, and how the specialized health care service plan intends to utilize that method to determine recovery of overpayments made as a result of fraud, shall be submitted to, and approved by, the department as elements of the specialized health care service plan's antifraud plan established and approved pursuant to Section 1348. The specialized health care service plan's utilization of a statistically reliable method shall help protect and promote the interests of enrollees and shall help ensure a stable health care delivery system. The statistically reliable method shall be consistent with direction provided by the International Standards for the Professional Practice of Internal Auditing and the guidance provided by the International Professional Practices Framework guide, which are both produced by the Institute of Internal Auditors.

(2) Pursuant to its antifraud plan established and approved pursuant to Section 1348, a specialized health care service plan shall provide a written notice of suspected fraud to a provider that includes, at a minimum, all of the following:

(A) A clear description of the specialized health care service plan's statistically reliable methodology. The description shall include informa-

tion that ensures that the sample size used to calculate the repayment amount is consistent with the professional guidance provided in the 2009 edition of the American Institute of Certified Public Accountants' Audit Sampling Considerations of Circular A-133 Compliance Audits.

(B) A clear description of the universe of claims from which the statistical random sample was drawn and, if different, the universe of claims upon which the statistical analysis was applied to generate the recovery amount.

(C) A clear explanation of how the specialized health care service plan's statistically reliable methodology was utilized in the specialized health care service plan's findings of suspected fraud.

(D) Notice that a provider may dispute the specialized health care service plan's findings within 45 working days from the date of receipt of the notice of suspected fraud.

(E) The following information for each of the claims in the statistical sample that was utilized in the specialized health care service plan's findings:

(i) The claim number.

(ii) The name of the patient.

(iii) The date of service.

(iv) The date of payment.

(v) A clear explanation of the basis upon which the specialized health care service plan suspects the claim is fraudulent.

(3) A specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to recover overpayments made as a result of suspected fraud only if the universe of claims upon which the statistical analysis is performed consists only of those claims made between 365 days from the date of payment of the earliest in time claim and the date of payment of the latest in time claim. Notice shall be mailed to the provider no later than 60 days following the date of payment of the latest in time claim.

(4) If the provider contests the specialized health care service plan's notice of suspected fraud, the provider, within 45 working days of the date of receipt of the notice of suspected fraud, shall send written notice to the specialized health care service plan stating the basis upon which the provider believes that the claims are not fraudulent. The specialized health care service plan shall receive and process this contested notice of suspected fraud as a provider dispute pursuant to subdivision (a) of this section, paragraph (1) of subdivision (h) of Section 1367, and the regulations promulgated thereunder.

(5) A specialized health care service plan may offset the amount the specialized health care service plan disclosed as overpaid to the provider in an uncontested notice of suspected fraud against the provider's current claim submissions only if all of the following requirements are met:

(A) The provider fails to reimburse the specialized health care service plan within 45 working days from the date of receipt by the provider of the notice of suspected fraud.

(B) The specialized health care service plan sends written notice to the provider no less than 10 working days prior to withholding current claim payments in which the specialized health care service plan, at a minimum,

states its intent to withhold current claim payments and identifies the claim payments that the specialized health care service plan intends to withhold.

(C) The withheld claim payments do not exceed the amount asserted by the specialized health care service plan to be owed to the specialized health care service plan in its notice of suspected fraud.

(6) This section does not limit or remove a specialized health care service plan's obligation to comply with its antifraud plan established pursuant to Section 1348, or to limit or remove the specialized health care service plan's obligation to comply with the requirements for claims subject to subdivision (a).

(7) This subdivision does not limit or remove a specialized health care service plan's ability to recover overpayments as long as recovery is consistent with applicable law, including subdivision (a) and the regulations promulgated thereunder.

(8) This subdivision does not apply to claims submitted by a physician and surgeon for medical or surgical services that are outside the scope of practice of an optometrist pursuant to the Optometry Practice Act (Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code).

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

HISTORY:

Added Stats 1986 ch 957 § 1. Amended Stats 1989 ch 968 § 1; Stats 1992 ch 747 § 1 (AB 2656), ch 1357 § 1 (SB 382); Stats 1994 ch 614 § 3 (SB 1832); Stats 1996 ch 711 § 1 (SB 1478); Stats 2000 ch 825 § 3 (SB 1177), ch 827 § 3 (AB 1455); Stats 2009 ch 140 § 98 (AB 1164), effective January 1, 2010; Stats 2018 ch 525 § 1 (AB 1092), effective January 1, 2019; Stats 2019 ch 113 § 4 (AB 1802), effective January 1, 2020.