§ 1371.35. Requirements for health care service plans to reimburse claims for emergency services; Time limits; Interest on late payments; Exceptions [Operative January 1, 2026]

(a)(1) A health care service plan, including a specialized health care service plan, shall reimburse a complete claim or portion thereof, whether in state or out of state, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the health care service plan. If a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, a health care service plan shall notify the claimant, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the health care service plan.

(2) The notice that a claim or portion thereof, is contested shall identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim.

(3) The notice that a claim or portion thereof, is denied shall identify the portion of the claim that is denied, by procedure or revenue code, and the specific reasons for the denial, including any defect or impropriety.

(b) If a claim, or portion thereof, is not reimbursed by delivery to the claimant's address of record within 30 calendar days after receipt, the plan shall pay interest at a rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period. A health care service plan shall automatically include all interest that has accrued pursuant to this section in the payment made to the claimant, without requiring a request therefor. A plan failing to comply with this requirement shall pay the claimant the greater of an additional fifteen dollars ($15) or a fee of 10 percent of the accrued interest.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from

an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 calendar days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 calendar days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 calendar days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 calendar days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 calendar days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 calendar days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within 30 calendar days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 calendar days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within 30 calendar days after receipt of the additional information, the plan shall pay interest at the rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period. A health care service plan shall automatically include the interest due in the payment made to the claimant, without requiring a request therefor.

(f) The obligation of the 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. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider,

without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

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

(m) The department may issue compliance guidance and amend regulations for consistency with this section. The guidance and amendments shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2027.

(n) This section shall become operative on January 1, 2026.

HISTORY:

Added Stats 2024 ch 763 § 5 (AB 3275), effective January 1, 2025, operative January 1, 2026.