§ 1371.36. Denial of payment based on authorization

(a) A health care service plan shall not deny payment of a claim on the basis that the plan, medical group, independent practice association, or other contracting entity did not provide authorization for health care services that were provided in a licensed acute care hospital and that were related to services that were previously authorized, if all of the following conditions are met:

(1) It was medically necessary to provide the services at the time.

(2) The services were provided after the plan's normal business hours.

(3) The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made.

(b) This section shall not apply to investigational or experimental therapies, or other noncovered services.

HISTORY:

Added Stats 2000 ch 827 § 5 (AB 1455), effective January 1, 2001.