Expiration Date: Until Withdrawn

DEPARTMENT OF MANAGED HEALTH CARE
980 Ninth Street, Suite 500
Sacramento, CA 95814

September 4, 2003

DEPARTMENT ADVICE NO.: 03-07

TOPIC: Implementation Of The Claim Settlement Practices and Dispute Mechanisms Regulations. (Sections 1300.71 and 1300.71.38 of the California Code of Regulations)

Subject Matter:

A number of questions have arisen since the promulgation of the Claim Settlement Practices and Dispute Mechanisms Regulations. (Sections 1300.71 and 1300.71.38 of the California Code of Regulations). This Advisory outlines the expected timeline relating to implementation, plan reporting and enforcement.

Action:

Implementation Requirement:

The Claim Settlement Practices and Dispute Mechanisms Regulations were approved by the Office of Administrative Law on July 24, 2003, and are effective August 25, 2003. Health Plans and their capitated providers must be fully compliant with the regulations' claim processing and dispute resolution mechanism standards including the updating of all contractual arrangements and the commencement of data collection activities by January 1, 2004.

Filing Requirements Timetable:

January 1, 2004	Full Compliance Deadline for the implementation of the Claim Settlement Practices and Dispute Mechanisms Regulations.
January 15, 2004	Health Plans must submit their Annual Plan Dispute Resolution Mechanism Report to the Department required by Health and Safety Code § 1367(h)(3) in the same format that was utilized last year. A copy of the template is attached to this Advisory.

April 30, 2004	Capitated Providers must submit their first Quarterly Claims Payment Performance Report to their contracting health plans.
May 15, 2004	Health Plans must submit their first Quarterly Claims Payment and Dispute Resolution Mechanisms Report to the DMHC, including information submitted by their capitated providers. The electronic format will be supplied by the DMHC.
July 31, October 31, and January 31	Capitated Providers Quarterly Claims Payment Performance Report due to their contracting health plans.
August 31, November 30 and February 28	Health Plan Quarterly Claims Payment and Dispute Resolution Mechanisms Reports due to the DMHC.
January 15, 2005	Health Plan initial Annual Plan Claims Payment and Dispute Resolution Mechanism Report due to the DMHC – to include claims and dispute data from October 1, 2003, through September 30, 2004. The electronic format will be supplied by the DMHC.

Enforcement of Claims Payment Timeliness and Dispute Resolution Standards:

Requirements of Sections 1371 and 1371.35 of the Health and Safety Code, which set forth the timeliness standards for the adjudication of complete claims, are current requirements that apply to all pending claims submissions. Health Plans and their capitated providers who pay claims are expected to meet their statutory obligations. The Department cautions all payors that the failure to process and adjudicate current claim submissions consistent with the claims payment requirements set forth in the Knox-Keene Act may serve as a basis for an enforcement action or the assessment of a penalty.

With regard to the specific standards, including mandatory contract provisions, processing deadlines, mandated acknowledgements and disclosure requirements, set forth in the Claim Settlement Practices and Dispute Mechanisms Regulations, Sections 1300.71 and 1300.71.38 of the California Code of Regulations, Health Plans and other payors are required to receive and adjudicate any claim submission pertaining to services rendered on or after January 1, 2004, in full compliance with the Claim Settlement Practices and Dispute Mechanisms Regulations.

For further information, please contact Kevin F. Donohue at (916) 445-9753.

Authority:

Health and Safety Code sections 1371 and 1371.35; California Code of Regulations, title 28, sections 1300.71 and 1300.71.35.

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

Report of Dispute Resolution Mechanism

Reporting Period: October 1, 2001 through September 30, 2002

Plan Name: _____
Health Care Service Plan's Full Name

Contact Name/Title: _____
First and Last Names

Contact Address: _____
Street Address, City, State ZIP Code

Contact Phone: (___) _____ Contact Fax: (___) _____
(area code) (area code)

Contact Address: e-Mail @ _____

SUBMISSIONS	NUMBER
Total Number of Providers Submitting Disputes:	
Total Number of Disputes[1] Submitted to Plan:	
Total Number of Claims Disputes	
Total Number of Billing Disputes	
Total Number of Contract Disputes	
Total Number of Utilization Management Disputes	
Total Number of Other Disputes	
Total Number of Disputes Resolved Within 45 Working Days	
Total Number of Disputes That Resulted In A Written Determination	

[1] A notice of dispute referencing multiple claims shall be counted as one (1) dispute.

SUMMARY DISPOSITION: Claims Disputes[1]	NUMBER
Total Number Resolved in Favor of Provider:	
Total Number Resolved in Favor of Plan:	
Total Number with Pending Resolution:	

SUMMARY DISPOSITION: Billing Disputes	NUMBER
Total Number Resolved in Favor of Provider:	
Total Number Resolved in Favor of Plan:	
Total Number with Pending Resolution:	

SUMMARY DISPOSITION: Contract Disputes	NUMBER
Total Number Resolved in Favor of Provider:	
Total Number Resolved in Favor of Plan:	
Total Number with Pending Resolution:	

SUMMARY DISPOSITION: Utilization Management Disputes	NUMBER
Total Number Resolved in Favor of Provider:	
Total Number Resolved in Favor of Plan:	
Total Number with Pending Resolution:	

SUMMARY DISPOSITION: Other Disputes	NUMBER
Total Number Resolved in Favor of Provider:	
Total Number Resolved in Favor of Plan:	
Total Number with Pending Resolution:	

Disclose In An Informative Summary Any Emerging Or Established Patterns Of Provider Disputes And How That Information Has Been Used To Improve The Plans Administrative Capacity, Plan-Provider Relations, Claim Payment Procedures, Quality Of Care Assurance System (Process) And Quality Of Patient Care (Results):

VERIFICATION

I, the undersigned, have read and signed this report and know the contents thereof, and verify that to the best of my knowledge and belief, the information included in this report is true.

By: _____

(Signature of Individual Authorized to Sign on Behalf of the Plan.)

Name: _____

(Typed or Printed)

Title: _____