From: DMHC Licensing eFiling

Subject: APL 23-008 - Health Plan Requirements to Timely Pay Claims

Date: Friday, March 24, 2023 12:05 PM

Attachments: APL 23-008 - Health Plan Requirements to Timely Pay Claims (3.24.2023)

Dear Health Plan Representative:

The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-008 to highlight and remind plans of timely payment and utilization management obligations with respect to hospitals.

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: March 24, 2023

TO: All Health Care Service Plans

FROM: Sarah Ream
Chief Counsel

SUBJECT: APL 23-008 - Health Plan Requirements to Timely Pay Claims

The DMHC has been contacted by a number of hospitals informing the DMHC that many health plans are not following the claims payment requirements which has resulted in delayed or non-payment of rendered services. Health care service plans ("plans") have a legal obligation to timely pay claims submitted by providers, including hospitals, that provide covered services to the plans' enrollees. In addition, plans must timely review and respond to provider requests for authorization of health care services.

This All Plan Letter (APL) highlights and reminds plans of those timely payment and utilization management obligations with respect to hospitals. The Department of Managed Health Care (DMHC) encourages plans to go beyond the minimum requirements regarding timely payment and to evaluate how plans can support the hospitals in their networks to ensure enrollees continue to have timely and geographic access to hospital services.

Plans must comply with all the claims payment and utilization management requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene Act") and its implementing regulations.[1] These requirements include the following:

- A plan must pay all claims within the statutory timeframes.[2] If the plan pays a claim beyond the statutory timeframes, the plan's payment must automatically

[1] The Knox-Keene Act is set forth in California Health and Safety Code sections 1340 *et seq.* References herein to "Section" are to sections of the Knox-Keene Act. References to "Rule" are to the California Code of Regulations, title 28.
[2] *See* Section 1371, subdivision (a)(1); Section 1371.35, subdivision (a); Rule 1300.71, subdivision (g).

include specified interest and/or monetary penalties.[3] If the plan contests a portion of a claim, the plan must reimburse any uncontested portions of the claim within the statutory timeframes.[4]

- If a plan contests or denies all or a portion of a claim, the plan must specify the reason(s) for the contest or denial within the statutory timeframes.[5]
  - If the plan needs additional information to complete a claim, the plan must request such additional information within the statutory timeframes.[6]
- Plans may not request irrelevant or unnecessary information from providers during claims processing, and must specify why the requested information is necessary to complete the claim.[7]
- A plan or its delegate, if applicable, must timely reimburse complete claims for authorized services or for services that do not require prior authorization. The plan or its delegate are prohibited from rescinding or modifying an authorization after the authorized service has been rendered.[8]
- A plan must approve, modify, or deny, based on medical necessity, requests by providers prior to or concurrent with the provision of health care services within a timely fashion but no later than five business days from the plan's receipt of the request and no later than 72 hours if the enrollee faces an imminent and serious threat to their health.[9]

The DMHC may take enforcement action against plans that fail to comply with the timely payment requirements outlined above.

Finally, health plans should review the policies and procedures regarding claims submission and processing, which they have disseminated to their contracted providers, to ensure those policies and procedures are up-to-date and reflect the current practices of the plan. Health plans should also evaluate whether additional provider training

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[3] *See* Section 1371, subdivisions (a)(2) and (a)(4); Section 1371.35, subdivision (b); Rule 1300.71, subdivision (i)(1)-(2).
[4] *See* Section 1371, subdivision (a)(1); Section 1371.35, subdivision (a); Rule 1300.71, subdivision (g).
[5] *See* Section 1371, subdivision (a)(1); Section 1371.35, subdivision (a); Rule 1300.71, subdivision (d)(1); Rule 1300.71, subdivision (h).
[6] *See* Section 1371, subdivision (a)(4); Section 1371.35, subdivision (e).
[7] *See* Section 1371, subdivision (a)(3); Rule 1300.71, subdivision (d)(2).
[8] *See* Section 1371.8.
[9] *See* Section 1367.01, subdivisions (h)(1) and (h)(2).

regarding claims submission and processing would be helpful to ensure providers understand the plans' processes for submitting claims.

If you have questions regarding this APL, please contact your health plan's assigned reviewer in the DMHC's Office of Plan Licensing.