Step 1- Health Plan Quarterly Claim Report Instructions	
See footer for reporting due dates.	***RBO to report to Plan within 30 days of the close of each quarter.***
See page 23 of 37, starting with line 11 for the law	***Plan to report to DMHC within 60 days of the close of each quarter.***
This step should only be filled out when Health Plans are NON-COMPLIANT.	
Claims Payment Timeliness	**Quarter Ended 12/31, 3/31, 6/30, 9/30**
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of Commercial and Healthy Family (HMO) claims paid, denied, adjusted or contested within 45 days	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 working days	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of Medi-Cal claims paid, denied, adjusted or contested 45 working days	If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total Number of claims that were PAID or ADJUSTED during the reporting period.	Required beginning 4Q 2006. If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.

Reporting Due Dates

1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr= RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Total Number of claims that were PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) during the reporting period.	Required beginning 4Q 2006. If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total Number of claims that were PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	Required beginning 4Q 2006. If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of emergency service claims (FN4) paid, denied, adjusted or contested during the reporting period.	Required beginning 4Q 2006. If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS, Specialized and Medi-Cal) during the reporting period.	Required beginning 4Q 2006. If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of claims received during the reporting period.	Required beginning 4Q 2006. If Plan meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.

Disclosure of Emerging Claims Payment Deficiencies	
Failed to forward at least 95% of misdirected claims consistent with sections 1300.71 (b) (2) (A) and (B) during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to accept a late claim consistent with sections 1300.71 (b) (4) at least 95% of the time during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d) (1) at least 95% of the time for the affected claims during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.

Reporting Due Dates
1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr= RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Failed to contest or deny a claim, or portion thereof, within the timeframes of section 1300.71 (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Requested reimbursement of an overpayment of a claim inconsistent with the provisions of 1300.71 (b) (5) and (d) (3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Rescinded or modified an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Imposed a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1).	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Imposed a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1).	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to establish that the requests for medical records were required to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to establish that the requests for medical records were required to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Corrective Action	
Indicate below any corrective action the plan has instituted.	Provide details

Reporting Due Dates
1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr= RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Steps 2 & 3 - RBO/Capitated Provider/Claims Processing Organization Quarterly Claim Reporting Instructions	
See footer for reporting due dates.	***RBO/Capitated Provider/Claims Processing Organization to report to Plan within 30 days of the close of each quarter.***
See page 23 of 37, starting with line 11 for the law	***Plan to report to DMHC within 60 days of the close of each quarter.***
This step should only be filled out when RBO's are NON-COMPLIANT.	
Claims Payment Timeliness (Step 2)	**Quarter Ended 12/31, 3/31, 6/30, 9/30**
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of Commercial and Healthy Family (HMO) claims paid, denied, adjusted or contested within 45 days	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 working days	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested 45 working days	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.

Reporting Due Dates

1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr = RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Total Number of claims that were PAID or ADJUSTED during the reporting period.	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total Number of claims that were PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) during the reporting period.	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total Number of claims that were PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of emergency service claims (FN4) paid, denied, adjusted or contested during the reporting period.	Required beginning 4Q 2006. If Plan (out) RBO/Capitated Provider/Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If Plan does not meet the 95% threshold, then enter data.
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS, Specialized and Medi-Cal) during the reporting period.	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.
Total number of claims received during the reporting period.	If RBO/Capitated Provider /Claims Processing Organization meets or exceeds the 95% claims payment timeliness threshold, then report "0" for the quarter. If RBO does not meet the 95% threshold, then enter data for each month in the quarter.

Disclosure of Emerging Claims Payment Deficiencies (Step 3)	
Failed to forward at least 95% of misdirected claims consistent with sections 1300.71 (b) (2) (A) and (B) during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to accept a late claim consistent with sections 1300.71 (b) (4) at least 95% of the time during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.

Reporting Due Dates
1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr = RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d) (1) at least 95% of the time for the affected claims during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to contest or deny a claim, or portion thereof, within the timeframes of section 1300.71 (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Requested reimbursement of an overpayment of a claim inconsistent with the provisions of 1300.71 (b) (5) and (d) (3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Rescinded or modified an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Imposed a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1).	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Imposed a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1).	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to establish that the requests for medical records were required to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Failed to establish that the requests for medical records were required to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period.	Check only if it applies. If it applies, then enter narrative in the box provided to describe the corrective action plan to correct this deficiency.
Corrective Action	
If "Other" is indicated as a corrective action above, please specify the details in the text box below.	Provide details

Reporting Due Dates

1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr = RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Step 4 - Health Plan Quarterly Claim Reporting Instructions	
Nothing to Report for Step 1	Check this box if the Health Plan meets the 95% threshold for ALL questions in Step 1
Nothing to Report for Step 2	Check this box if ALL RBO/Capitated Providers/Claims Processing Organizations meet the 95% threshold for ALL questions in Step 2 OR if the Plan does not contract with RBO/Capitated Providers/Claims Processing Organizations.
Nothing to Report for Step 3	Check this box if ALL RBO/Capitated Providers/Claims Processing Organizations have no Emerging Claims Payment Pattern Deficiencies to disclose or if the Plan does not contract with RBO/Capitated Providers/Claims Processing Organizations.
Verification	Check this box to certify that the information included in this report are true and correct.

Reporting Due Dates
1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr = RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Steps 1 & 2 - Health Plan Annual Report Instructions for Self Reporting	
This step must be completed by all Health Plans, regardless of compliance status.	
See footer for reporting due dates.	***RBO to report to Plan within 30 days of the close of the 3rd Quarter (10/30)***
See page 23 of 37 starting with line 22	***Plan to report to DMHC within 15 days of the close of each calendar year (1/15)***
Claims Payment Timeliness (Step 1)	**Covers 10/1 through 9/30**
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period	Enter data for each quarter.
Total number of Commercial and Healthy Family (HMO) claims paid, denied, adjusted or contested within 45 days	Enter data for each quarter.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period	Enter data for each quarter.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days	Enter data for each quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period	Enter data for each quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 working days	Enter data for each quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested 45 working days	Enter data for each quarter.
Total Number of claims that were PAID or ADJUSTED during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total Number of claims that were PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total Number of claims that were PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total number of emergency service claims (FN4) paid, denied, adjusted or contested during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Steps 1 & 2 - Health Plan Annual Report Instructions for Self Reporting	
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS, Specialized and Medi-Cal) during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total number of claims received during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.

Plan's Compliance	
With handling misdirected claims consistent with sections 1300.71 (b) (2) (A) and (B) during the reporting period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With accepting a late claim consistent with sections 1300.71 (b) (4) at least 95% of the time during the reporting period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With providing an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d) (1) at least 95% of the time for the affected claims during the reporting period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
timeframes of section 1300.71 (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With providing the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With requesting reimbursement of an overpayment of a claim inconsistent with the provisions of 1300.71 (b) (5) and (d) (3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With rescinding or modifying an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With imposing a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1).	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With imposing a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1).	Check "yes" or "no" to attest to the health plan's compliance with this requirement.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Steps 1 & 2 - Health Plan Annual Report Instructions for Self Reporting	
With requesting medical records to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.
With requesting emergency services and professional provider medical records to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period.	Check "yes" or "no" to attest to the health plan's compliance with this requirement.

Disclosure of Emerging Claims Payment Deficiencies	
Did the Plan disclose any deficiencies in the "Quarterly Claims Settlement Practices Report (in the previous four quarters or more)?	Check "yes" or "no", consistent with previously filed quarterly reports.
Was the Plan required to institute a corrective action plan (in the previous four quarters)?	Check "yes" or "no", consistent with previously filed quarterly reports.
If the response was "Yes" to either question, provide a summary on any established or documented patterns of claims payment deficiencies, outlining the corrective action that has been undertaken, and explain how the corrective action (instituted) has assisted the plan to comply with the rules and regulations.	If "yes" was entered in either or both of the items above, then enter narrative in the box provided to describe the corrective action plan to correct the deficiency(ies).

Dispute Resolution Mechanism Report (Step 2)	
Total Number of Claims Payment/Billing Disputes	
Number of contracted claims payment disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Number of non-contracted claims payment disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Total Number of Utilization Management Disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Total Number of Other Disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Total Number of Claims Payment/Billing Disputes	
Professional Providers	Enter total.
Institutional Providers	Enter total.
Other Providers	Enter total.
Total Number of Disputes to Plan	Enter total.
Total disputes resolved within 45 working days	Enter total.
Total disputes resulting in written determination	Enter total.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Steps 1 & 2 - Health Plan Annual Report Instructions for Self Reporting	
Narrative Summary	
Provide an informative summary of any emerging or established patterns of provider disputes and demonstrate how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality of care assurance system (process), and quality of patient care (results).	Enter narrative.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Step 3 - Health Plan Annual Report Instructions Regarding RBO/Capitated Provider/Claims Processing Organization Data	
This step must be completed by all Health Plans, regardless of compliance status.	
See footer for reporting due dates.	***RBO/Capitated Provider /Claims Processing Organizations to report to Plan within 30 days of the close of each quarter.***
See page 23 of 37 starting with line 22	***Plan to report to DMHC within 15 days of the close of each calendar year (1/15)***
Claims Payment Timeliness	**Covers 10/1 through 9/30**
Total number of Commercial and Healthy Families (HMO) claims paid, denied, adjusted or contested during the reporting period	Enter data for each quarter.
Total number of Commercial and Healthy Family (HMO) claims paid, denied, adjusted or contested within 45 days	Enter data for each quarter.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested during the reporting period	Enter data for each quarter.
Total number of PPO/POS/Specialized claims paid, denied, adjusted or contested within 30 working days	Enter data for each quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested during the reporting period	Enter data for each quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested within 30 working days	Enter data for each quarter.
Total number of Medi-Cal claims paid, denied, adjusted or contested 45 working days	Enter data for each quarter.
Total Number of claims that were PAID or ADJUSTED during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total Number of claims that were PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total Number of claims that were PAID or ADJUSTED beyond 45 working days (Commercial, Healthy Families and Medi-Cal) and/or 30 working days (PPO, POS, and Specialized) that included the payment of applicable interest and/or penalty during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total number of emergency service claims (FN4) paid, denied, adjusted or contested during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Step 3 - Health Plan Annual Report Instructions Regarding RBO/Capitated Provider/Claims Processing Organization Data	
Total number of those emergency service claims PAID or ADJUSTED within 45 working days (Commercial, Healthy Families and Medi-Cal) or 30 working days (PPO, POS, Specialized and Medi-Cal) during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.
Total number of claims received during the reporting period.	Required beginning 4Q 2006. Enter data for each quarter.

Payor's Compliance	
Date of audit by health plan.	Insert date.
Did the health plan audit the payor's procedure and/or practice for handling of misdirected claims consistent with sections 1300.71 (b) (2) (A) and (B) during the reporting period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for accepting a late claim consistent with sections 1300.71 (b) (4) at least 95% of the time during the reporting period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for providing an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d) (1) at least 95% of the time for the affected claims during the reporting period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for contesting or denying a claim, or portion thereof, within the timeframes of section 1300.71 (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for providing the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Step 3 - Health Plan Annual Report Instructions Regarding RBO/Capitated Provider/Claims Processing Organization Data	
Did the health plan audit the payor's procedure and/or practice for requesting reimbursement of an overpayment of a claim inconsistent with the provisions of 1300.71 (b) (5) and (d) (3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for rescinding or modifying an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for imposing a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1).	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for imposing a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1).	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for requesting medical records to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.
Did the health plan audit the payor's procedure and/or practice for requesting emergency services and professional provider medical records to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period.	Enter Yes/No/reasons for the following: 1) Was the section audited for compliance? Yes **No 2) If yes, was the payor compliant? Yes No ** 3) If no, then state reason for not auditing.

Disclosure of Emerging Claims Payment Deficiencies	
Did the Payor disclose any deficiencies in the "Quarterly Claims Settlement Practices Report (in the previous four quarters or more)?	Check "yes" or "no", consistent with previously filed quarterly reports..
Was the Payor required to institute a corrective action plan (in the previous four quarters)?	Check "yes" or "no", consistent with previously filed quarterly reports..

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Step 3 - Health Plan Annual Report Instructions Regarding RBO/Capitated Provider/Claims Processing Organization Data	
If the response was "Yes" to either question, provide a summary on any established or documented patterns of claims payment deficiencies, outlining the corrective action that has been undertaken, and explain how the corrective action (instituted) has assisted the plan to comply with the rules and regulations.	If "yes" was entered in either or both of the items above, then enter narrative in the box provided to describe the corrective action plan to correct the deficiency(ies).
Total Number of Claims Payment/Billing Disputes	
Number of contracted claims payment disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Number of non-contracted claims payment disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Total Number of Utilization Management Disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Total Number of Other Disputes	Enter total number in favor of provider, in favor of plan, and pending resolution.
Total Number of Claims Payment/Billing Disputes	
Professional Providers	Enter total.
Institutional Providers	Enter total.
Other Providers	Enter total.
Total Number of Disputes to Plan	Enter total.
Total disputes resolved within 45 working days	Enter total.
Total disputes resulting in written determination	Enter total.
Narrative Summary	
Provide an informative summary of any emerging or established patterns of provider disputes and demonstrate how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality of care assurance system (process), and quality of patient care (results).	Enter narrative.

Reporting Due Dates:
RBO 1st Qtr = 4/30
RBO 2nd Qtr = 7/31
RBO 3rd Qtr = 10/31
RBO 4th Qtr = 1/31
Plan's Annual Report Due Date = 1/15

Step 4 - Health Plan Annual Report Instructions	
Nothing to Report for Step 3 of this report	Check this box if the plan does not contract with any providers that pay claims.
Verification	Check this box to certify that the information included in this report are true and correct.

Reporting Due Dates
1st Qtr = RBO 4/30; Plan 5/30
2nd Qtr = RBO 7/31; Plan 8/31
3rd Qtr = RBO 10/31; Plan 11/30
4th Qtr = RBO 1/31; Plan 3/1

Regulations/Statutes	Text of Citation
1300.71 (b) (2) (A) and (B)	Claim Filing Deadline: If a claim is sent to a plan that has contracted with a capitated provider that is responsible for adjudicating the claim, then the plan shall do the following: For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan. For a provider claim that does not involve emergency service or care: (i) if the provider that filed the claim is contracted with the plan's capitated provider, the plan within ten (10) working days of the receipt of the claim shall either: (1) send the claimant a notice of denial, with instructions to bill the capitated provider or (2) forward the claim to the appropriate capitated provider; (ii) in all other cases, the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.
1300.71 (b) (4)	A plan or a plan's capitated provider that denies a claim because it was filed beyond the claim filing deadline, shall, upon provider's submission of a provider dispute pursuant to section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to Health and Safety Code section 1371 or 1371.35, which ever is applicable, and these regulations.
1300.71 (d) (1)	Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Claims. A plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).
1300.71 (h) (1)(2)(3)	Time for Contesting or Denying Claims. A plan and a plan's capitated provider may contest or deny a claim, or portion thereof, by notifying the provider, in writing, that the claim is contested or denied, within thirty (30) working days after the date of receipt of the claim by the plan and the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the claim by the plan or the plan's capitated provider. To the extent that a full service health care service plan that meets the definition of an HMO as set forth in paragraph 1300.71(a)(9) also maintains a PPO or POS line of business, the plan shall contest or deny claims relating to or arising out of non-HMO lines of business within thirty (30) working days. If a specialized health care service plan contracts with a plan that is a health maintenance organization to deliver, furnish or otherwise arrange for or provide health care services for that plan's enrollees, the specialized plan shall contest or denied claims received for those services within thirty (30) working days. A request for information necessary to determine payer liability from a third party shall not extend the Time for Reimbursement or the Time for Contesting or Denying Claims as set forth in sections (g) and (h) of this regulation. Incomplete claims and claims for which "information necessary to determine payer liability" that has been requested, which are held or pended awaiting receipt of additional information shall be either contested or denied in writing within the timeframes set forth in this section. The denial or contest shall identify the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability
1300.71(b)(1)	Claim Filing Deadline. Neither the plan nor the plan's capitated provider that pays claims shall impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If a plan or a plan's capitated provider is not the primary payer under coordination of benefits, the plan or the plan's capitated provider shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.
1300.71(a)(8)(H)	A "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern:" as set forth in section (s)(4): [….] The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;
1300.71(a)(8)(I)	A "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern:" as set forth in section (s)(4): [….] The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;
1300.71.38(b)	Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

1300.71 (b) (5)	Claims Filing Deadline A plan or a plan's capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the over paid claim. The written notice shall include the information specified in section (d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.
1300.71(d)(3)(4)(5)(6)	Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Claims If a plan or a plan's capitated provider determines that it has overpaid a claim, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. If the provider contests the plan's or the plan's capitated provider's notice of reimbursement of the overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, shall send written notice to the plan or the plan's capitated provider stating the basis upon which the provider believes that the claim was not over paid. The plan or the plan's capitated provider shall receive and process the contested notice of overpayment of a claim as a provider dispute pursuant to Section 1300.71.38 of title 28. If the provider does not contest the plan's or the plan's capitated provider's notice of reimbursement of the overpayment of a claim, the provider shall reimburse the plan or the plan's capitated provider within 30 working days of the receipt by the provider of the notice of overpayment of a claim. A plan or a plan's capitated provider may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse the plan or the plan's capitated provider within the timeframe of section (5) above and (ii) the provider has entered into a written contract specifically authorizing the plan or the plan's capitated provider to offset an uncontested notice of overpayment of a claim from the contracted provider's current claim submissions. In the event that an overpayment of a claim or claims is offset against a provider's current claim or claims pursuant to this section, the plan or the plan's capitated provider shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.
1300.71(a)(8)(T)	A "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. The following practices, policies and procedures may constitute a basis for a finding that the plan or the plan's capitated provider has engaged in a "demonstrable and unjust payment pattern:" as set forth in section (s)(4): [….] An attempt to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization, inconsistent with section 1371.8, on three (3) or more occasions over the course of any three-month period.

Health & Safety Code	Text of Citation
1371	Reimbursement of claims; contested claims A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, 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. 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. Any plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee. For the purposes of this section, a claim, or portion thereof, is reasonably contested where 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. 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, then 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. 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
1371.35	Time limits for reimbursement, contest, or denial of certain claims; what constitutes a complete claim; claims excepted from time limits (a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete 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 complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, 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, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an unc reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b). (b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30- or 45-working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest 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 the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefore. (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 working 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 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working 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 s equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working 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 working 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 the respective 30- or 45-working 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 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 claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per year or interest 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 the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefore. (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
1371.8	A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.