Policy and Procedure No: CL 10.7	**Revision No: 7**
Division: Managed Care Division	
Department: Claims Operations	
Title: PHC-CA Claims Compliance Timeliness, Interest, and Penalty Payments	
Effective Date: 1/1/2006	
Supersedes Policy No: CL 18.0, CL 10.0, CL 10.1, CL 10.2, CL 10.3, CL 10.4, CL 10.5, CL 10.6	
Reviewed/Revised by: Nataliya Topuriya	**Review/Revision Date: 12/12/2025**
Approving Committee: Member Provider Committee	**Date: 12/16/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To ensure PHC California (the Health Plan) (1) acknowledges clean claims from providers in a timely manner; (2) makes timely payments to providers rendering services to Medi-Cal enrollees; and (3) pays any interest or penalties required for late-paid clean claims in compliance with state regulations and the Health Plan's contract with California's Department of Health Care Services (DHCS).

The Health Plan ensures that the plan, its subcontractors, and downstream subcontractors (if applicable) fully comply with the plan's DHCS Contract, applicable state and federal statutes and regulations, All Plan Letters (APLs), including Department of Health Care Services (DHCS) APL 23-020, and California Health and Safety Code Sections 1371 and 1371.35, and all other applicable policy guidance concerning prompt payments to providers. The Health Plan promptly communicates claims payment requirements to all subcontractors and downstream subcontractors.

Policy:

1. Timely Payment of Claims

    a. Effective January 1, 2026, Department of Managed Health Care APL 25-007 requires the Health Plan to reimburse complete claims within thirty (30) calendar days.

    b. The Health Plan pays all claims within the timeframes required by federal and state law, including California Health and Safety Code (HSC) §§ 1371, 1371.34 and 1371.35, and in accordance with the prompt payment standards outlined in the DHCS Contract for clean claims. This includes equivalent encounter submission, or bills or invoices sent by providers that adhere to billing and invoicing guidance, such as providers of Enhanced Care Management (ECM), Community Supports services, and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

    c. The Health Plan supports sufficient claims processing/tracking/payment system capabilities to meet contractual and statutory standards.

    d. DHCS encourages the Health Plan to go beyond the minimum statutory requirements, to the extent feasible, of the prompt payment of claims to support and sustain providers to ensure access to care. Some providers do not have the same financial reserves or

diverse payer mix as others and rely on prompt payment from the Medi-Cal program through the health plans to sustain services to Members.

e. In the event the Health Plan delegates the adjudication of claims for emergency service and care to a capitated subcontractor, the Health Plan must forward any claims that are misdirected to the Health Plan to the capitated subcontractor within (10) ten working days of receipt of the claim.

f. In the event the Health Plan delegates the adjudication of claims for non-emergency services to a capitated subcontractor, the Health Plan must forward any claims that are misdirected to the Health Plan to the appropriate capitated subcontractor within ten (10) working days of receipt of the claim. If the provider submitting a non-emergency services and care claim is not contracted with the Health Plan's capitated provider, the Health Plan must forward the misdirected claim to the appropriate provider within ten (10) working days of the receipt of the claim.

g. The Health Plan is required to comply with California Health and Safety (HSC) sections 1371 through 1371.35, which governs provider compensation.

2. Contested Claims and Denied Claims

a. If the Health Plan contests a part of a claim, it reimburses any uncontested portions of the claim within the statutory time limits.

b. If a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, the Health Plan shall notify the claimant, in writing, that the claim or portion thereof is contested or denied. The written notice of a contested or denied claim must be provided to the claimant as soon as practicable, but no later than thirty (30) calendar days after receipt of the claim. (Ref. California Health and Safety Code Sections 1371(a)(1) and 1371.35(a)(1), effective January 1, 2026).

c. 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.

d. 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.

e. The Health Plan completes reconsideration of denied or contested claims within thirty (30) calendar days after receiving additional information from the provider.

The Health Plan does not request irrelevant or unnecessary information from providers during claims processing. If the Health Plan needs additional information to complete the claim, it must specify why additional information is necessary to complete the claim and must do so within the statutory timelines. A claim, or portion thereof, is reasonably contested if 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 the Health Plan has received all information necessary to determine payer liability for a contested claim and does not reimburse a claim it has determined to be payable within thirty (30) calendar days of the receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning the first calendar day after the thirty (30) calendar-day period.

f. The Health Plan does not contest claims that are consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

3. Interest and Penalties

g. If the Health Plan does not pay a complete claim within thirty (30) calendar days of receipt, it pays the provider interest at the rate of fifteen (15) percent per annum beginning on the first calendar day after the thirty (30) calendar day period. The Health Plan automatically includes all applicable interest in any late payments to the provider.

h. If the Health Plan fails to meet the interest requirements, it also pays the provider the greater of either an additional fifteen dollars ($15.00) or ten percent (10%) of the accrued interest on the claim.

i. The requirements for interest and penalty applies to all claims, including claims for emergency services and care.

4. Payments Related to State Directed Payments

a. The Health Plan adheres to prompt payment requirements regardless of whether a provider's claim, bill, invoice, or equivalent encounter is tied to a State Directed Payment (SDP). The Health Plan is not subject to prompt payment of SDPs until directed by DHCS. The thirty (30) calendar-day standard outlined above does not apply when the SDP amount is not published before the service date.

5. Provider Training Responsibilities

a. The Health Plan ensures that provider manuals issued to network providers, subcontractors, and downstream subcontractors have up-to-date policies and procedures on how to submit complete claims to the Health Plan. This includes billing and invoicing processes for ECM providers, Community Supports providers, doulas, or other community-based providers unable to submit claims through an electronic file format.

b. The Health Plan ensures that all policies and procedures on claims processing, billing and invoicing are up-to-date and reflective of current practices. For reasonably contested claims, the Health Plan must give notice to the provider that identifies the portion of the claim that is contested, by procedure or revenue code, and must state the specific

information required from the provider to reconsider the claim, including any defect, impropriety, or additional information needed to adjudicate the claim. Claims and billing materials must be publicly accessible for all providers.

c. In addition to issuing clear policies and procedures, the Health Plan ensures that all providers are afforded education and training on the plan's billing, invoicing, and clean claims submission protocols. This includes education and training about the providers' obligation to refrain from billing enrollees for covered services, even if the Health Plan pays late or denies payment for a claim. The Health Plan ensures providers that do not bill on a fee-for-service basis are educated on the correct processes for submission of encounter data.

h. The Health Plan starts training within ten (10) working days of activating a new Network Provider and completes training within thirty (30) working days after the Health Plan places a newly contracted network provider on active status.

i. The Health Plan routinely evaluates the effectiveness of the training and adjusts as needed. DHCS encourages health plans to hold office hours or other open-door approaches to working with their providers, particularly in the event of systemic billing concerns.

j. DHCS recognizes that health plans have proven provider portal and electronic mechanisms to ease claims and equivalent encounter transactions. DHCS encourages plans to use standardized mechanisms to ease provider claims and equivalent encounter transactions. At a minimum, the Health Plan ensures providers have the training to effectively use electronic systems to help prompt submission of complete claims, equivalent encounters, or bills or invoices.

k. The Health Plan complies with the specific disclosure requirements to contracting providers set forth under Rule 1300.71(o), including:

    i. The complete fee schedule for the contracting provider consistent with the disclosures specified in section 1300.75.4.1(b); and

    ii. The detailed payment policies and rules and any non-standard coding methodologies used to adjudicate claims, unless otherwise prohibited by state law.

6. Dispute Resolution

a. Pursuant to HSC section 1367(h), the Health Plan maintains a fast, fair, and cost-effective dispute resolution process in place for providers, network providers, subcontractors, and downstream subcontractors to submit disputes related to claims and payments. This requirement applies for both contracted and non-contracted providers.

b. The Health Plan has a formal procedure to accept, acknowledge, and resolve provider, network provider, subcontractor, and downstream subcontractor disputes. The Health Plan issues a written determination of provider disputes within forty-five (45) working days after the date of receipt of the dispute.

c. The Health Plan is further responsible for ensuring that their Subcontractors and Network Providers follow all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by the Health Plan to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. See DHCS APL 23-012, and any superseding APLs, for more information on this topic.

d. In the event the Health Plan denies a claim because it was filed beyond the claim-filing deadline, the plan accepts and adjudicates the claim upon provider's submission of a provider dispute and the demonstration of good cause for the delay.

Procedure:

1. The Health Plan acknowledges electronic claims within two (2) working days of receipt via the California 277 file, and paper claims within fifteen (15) working days of receipt via written communication, i.e., mailed, fax, or emailed. This procedure applies to all providers, including Community Supports providers.

    a. The acknowledgement of receipt must disclose the recorded "date of receipt" as defined by 28 CCR 1300.71(c).

    b. Acknowledgement notices must be delivered in the same manner the claim was submitted, or through a mutually agreed method (e.g., phone, website, or electronic) that allows the provider to confirm receipt and the recorded date of receipt.

2. When the Health Plan does not pay a claim within thirty (30) calendar days of receipt, interest is automatically calculated by the claims adjudication system in the following cases:

    a. Complete claims paid beyond the statutory timeframe.

    b. A provider dispute is resolved in favor of the provider, in whole or in part. The Health Plan pays all outstanding payments, interest and penalties as required by law.

    c. Adjustments in which the Health Plan was at fault and the adjusted amount is paid after the time limitation.

    d. The Health Plan contested a claim in error and payment is beyond the time limitation.

    e. The Health Plan denied a claim in error and payment is beyond the time limitation.

3. Interest is paid automatically accrued by the Health Plan or its capitated provider in the following specific circumstances:

    a. After the Health 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 thirty (30) calendar days of receipt of that information.

b. If the Health Plan fails to provide the claimant with written notice that a claim has been contested or denied within 30 calendar days after the date of receipt of a clean claim (late notice).

c. If the Plan requests information from the provider that is not reasonably relevant or requests information from a third party that is in excess of the information necessary to determine payor liability but ultimately pays the claim in whole or in part (frivolous requests).

d. Interest is calculated at fifteen percent (15%) per annum for all claims including emergency services beginning the first calendar day after the thirty (30) calendar-day period.

e. If the Health Plan fails to meet this interest requirement, it must also pay the provider the greater of fifteen dollars ($15.00) or ten percent (10%) of the accrued interest on the claim.

4. All claim payments, denials and adjustments have the proper claim adjustment codes, reason codes and remark codes advising the provider of the payment methodology used to price the claim. This information is communicated to the provider via the remittance advice.

5. If a claim or a part thereof is denied by the Health Plan:

    a. The plan notifies the provider via remittance advice within thirty (30) calendar days after receipt of the claim. The remittance advice identifies the part of the claim that is denied and the reasons for denial. Providers who have agreed to receive RAs in an electronic format may also obtain a written Remittance Advice from the Health Plan's provider portal.

    b. The remittance advice identifies the portion of the claim that is denied by procedure and revenue code, and the specific information needed from the provider for the Health Plan to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim.

6. If a claim or a part thereof is contested by the Health Plan:

    a. The plan notifies the provider via remittance advice within thirty (30) calendar days after receipt of the claim. The remittance advice identifies the part of the claim that is contested and the reasons for being contested. Providers who have agreed to receive RAs in an electronic format may also obtain a written RA from the Health Plan's provider portal.

    b. The remittance advice identifies the portion of the claim that is contested by procedure and revenue code, and the specific information needed from the provider for the Health Plan to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim.

7. The Health Plan or its capitated provider, with the agreement of the contracted provider, may utilize alternate transmission methods to deliver any disclosure required by 28 CCR § 1300.71 so long as the contracted provider can readily determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

8. To the extent that the Health Insurance Portability and Accountability Act of 1996, as amended, limits the Health Plan's or the plan's capitated provider's ability to electronically transmit any required disclosures under 28 CCR § 1300.71, the plan or the plan's capitated provider shall supplement its electronic transmission with a paper communication that satisfies the disclosure requirements.

9. All remittance advice includes information about the provider's right to dispute the amount of payment, and the address and time limits for submitting a Provider Dispute.

10. The Provider Relations and Contracting Department, with the Claims Department, supports up-to-date policies and procedures and training for Network Providers on billing, invoicing and complete claim submission protocols.

Definitions:

1. Automatically: means the payment of interest due to a provider within five (5) working days of the payment of the claim without the need for any reminder or request by the provider.

2. Community Supports Provider: a contracted provider of DHCS-approved Community Supports. Community Supports providers are entities with experience and ability to supply one or more of the Community Supports approved by DHCS.

3. Complete Claim: Under the California Code of Regulations section 1300.71, a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides information necessary to determine payer liability.

4. Clean Claim

    a. As defined by DHCS, a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity; and

    b. A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d) or circumstance requiring special treatment that prevents prompt payment; and

    c. A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

5. Date of Contest, Date of Denial or Date of Notice: the date of post-mark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid.

6. Date of Receipt: the working day when a claim, by physical or electronic means, is first delivered to either the Health Plan's specified claims payment office, post-office box, or designated claims processor or to the plan's capitated provider for that claim. In the situation where a claim is sent to the incorrect party, the 'date of receipt' is the working day when the claim, by physical or electronic

means, is first delivered to the correct party responsible for adjudicating the claim..

Monitoring:

The Claims Department reviews, updates and presents this policy and procedure for approval to Member Provider Committee at least annually.

Reference(s):

1. California Department of Health Care Services Contract 11-88286, Exhibit A, Attachment 8, Provision 5, Claims Processing

2. California Department of Health Care Services OR Contract #22-20597, Exhibit A, Attachment III, Subsection 3.3.5 Claims Processing (pp. 171-2).

3. California Health and Safety Code Sections §§ 1371 through 1371.35

4. California Health and Safety Code §1300.71(a)(6) and 1300.71(b)(2)(A)

5. Code of Federal Regulations (CFR) section 447.45(b).

6. DHCS APL 23-020, Requirements for Timely Payment of Claims (REVISED), published October 12, 2023.

7. DMHC APL 25-007 (OFR) Assembly Bill 3275 Guidance (Claim Reimbursement)

Regulatory Agency Approval(s):

Date	Version	Agency/Purpose	Purpose	Response
8/9/2023	10.3	Department of Health Care Services (DHCS)	2024 Operational Readiness (O/R) R.0077	Approved
12/5/2023	10.4	DHCS	2024 O/R R.0088	Approved
9/15/2025	10.5	DMHC	Filing 20253578, APL 25-007	Comment Letter/Table
11/20/2025	10.6	DMHC	Filing 20253578-1, APL 25-007	Comment Letter/Table
	10.7	DMHC	Filing 20253578-3, APL 25-007	Pending