STATE OF CALIFORNIA Dave Jones, *Insurance Commissioner*

DEPARTMENT OF INSURANCE

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NOTICE

To: **All Admitted Health Insurers and Other Interested Persons**

Date: **November 5, 2012**

Subject: **Requirement for Insurers to Specify Policy or Contract Provisions and the Factual or Legal Basis for Denial of Claims for Payment of Medical Treatment**

This notice serves to remind insurers that the California Department of Insurance (CDI) is committed to enforcing provisions of the Insurance Code governing adequate disclosure to insureds of the specific contract or policy provisions on which their insurers or contracting providers rely when conveying decisions to deny, modify or delay health care services to their insureds asserting that the requested services are not a covered benefit. Please take notice that CDI evaluates insurers' communications with insureds and requires that insurers fully comply with Insurance Code Sections 10169(b) and 10123.13(a). These provisions require insurers to clearly specify the contractual provision of the health care plan or policy on which they rely in denying, modifying, or delaying an insured's request for health care services on coverage grounds.

Insurance Code Section 10169(b) states in pertinent part:

> …If an insurer, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the insured, the statement of decision shall clearly specify the provision in the contract that excludes the coverage.

Insurance Code Section 10123.13(a) states in pertinent part:

> "…The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function…"

The information required by these statutes is essential in order to communicate to policyholders the basis on which their request for health care services has been denied, modified or delayed and to enable them to make an informed decision about whether to file a grievance with their insurer or make a complaint to CDI's Consumer Services Division.

All health insurers should take the necessary steps to evaluate how they are responding to requests for health care services, and in particular decisions denying, modifying, or delaying such requests in order to ensure they are complying with the above statutes.

If you have questions, please contact Patricia Sturdevant, Deputy Insurance Commissioner, at 916-492-3578.