FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

CLAIMS	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2018	
		Policy # AHP ASO – CL001	
	AB1455 Claims Payments Guidelines	**Review Date** 05/09/2023	**Applicable to:** ☐ Medicare Advantage ☐ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Elisabeth Fagan, Director of Health Plan Operations	

1.0 PURPOSE

1.1 To ensure accurate and timely claims processing and payment in accordance with established guidelines and regulations, including AB 1455 (1999).

2.0 POLICY

2.1 Both contracted and non-contracted providers will have claims processed based upon established rules and guidelines.

2.2 The Plan will comply with all applicable regulatory and contractual requirements, including designating a Plan officer that is responsible for claims compliance and timely reporting information to the Department of Managed Health Care (Department).

3.0 DEFINITIONS

3.1 Reference chart within the procedure.

4.0 PROCEDURE

4.1 This is a quick reference tool to help a payer show a billing provider that a claim was paid properly, and the payment is not an example of an "unfair payment pattern." The "Most Common Topics" selected for this tool don't include every topic that may be useful to a payer.

4.2 The Physicians' Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting/billing medical services and procedures performed by physicians. CPT descriptive terms and identifying codes currently serve a wide variety of important functions in the field of medical nomenclature. CPT is also useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review. The CPT coding system is revised annually by the American Medical Association (AMA). Each year hundreds of additions, changes and deletions are made to the CPT coding system. These changes become effective on January 1st of each year.

4.3 CPT is required by federal law for all health insurance claim forms filed with Medicare, Medicaid, CHAMPUS and Federal Employee Health Plans and is accepted or required by all other third party payers. Proper use of CPT and other types of nationally recognized codes is now required under California regulations governing a "complete claim." The state and federal regulations are cited in this tool in the second and third columns, below.

4.4 The PMIC (Practice Management Information Corporation Inc.) publishes a concise version of the CPT, that doesn't list each of the procedure codes, just the guideline information for appropriate usage. Some of the topics in this book are listed in the table because they occur most frequently. The fourth and fifth columns in the table show the PMIC page numbers in both the 2002 and 2003 editions. The 2003 book will be the latest edition for dates of service through 12/31/03. When the 2004 edition is available, the page numbers in this tool may help in finding the citation for dates of service on or after 1/1/04.

Most Common Topics	**From 1300.71**	**Code of Federal Regulations TITLE 42**	**PMIC 2002 Page #**	**PMIC 2003 Page #**
Covered & non-covered services	(a) (2)	Part 411 Subpart A Section 411.4 - Section 411.15 Part 417 Subpart B Section 417.01	71	74
Multiple procedure reductions	(a) (2)	Part 414 Subpart B Section 414.40 (b)(3)	131	138
Multiple procedures –51 modifier	(a) (2)	Part 414 Subpart B Section 414.40 (b)(3)	165	177
Diagnostic Laboratory	(a) (2)	Generically in Part 414 Subparts B & C	186	199
Diagnostic Radiology	(a) (2)	Generically in Part 414 Subparts B & C	194	208
How to Complete HCFA 1500	(a) (2)	Part 424 Subpart C Section 424.32 through 424.40	253	276
POS codes	(a) (2)	Part 424 Subpart C Section 424.34 (2)	269	293
Evaluation &	(a) (2)	Generically in	172	185

Most Common Topics	From 1300.71	Code of Federal Regulations TITLE 42	PMIC 2002 Page #	PMIC 2003 Page #
Management Services (this section clearly states to use the CPT book for further and additional clarification)		Part 414 Subpart B		
Medicare Coding Requirements CPT Coding ICD 9 Coding/ICD 10 (this section clearly states to use ICD-9/ICD 10 and HCPS codes when billing for services rendered)	(a) (2)	Part 424 Subpart C Section 424.32 (1) and Section 424.34 (4) Part 424 Subpart C Section 424.32(2) and Section 424.34 (4)	113	119
Emergency Room Services: "An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." CPT Codes 99281-99285	(a) (2)	Part424 Subpart C Section 424.32 (1) and Section 424.34 (4) apply to Emergency room both regular providers and non-participating as defined in 422.2 Definitions	176	189
Services Rendered After Regular Office Hours: "The office-based physician may provide services after regular office hours, during the evening or night, or on Sundays and/or holidays. The following codes may be reported	(a) (2)	Part424 Subpart C Section 424.32 (1) and Section 424.34 (4) apply to Emergency room both regular providers and non-participating as defined in 422.2	172	185

Most Common Topics	From 1300.71	Code of Federal Regulations TITLE 42	PMIC 2002 Page #	PMIC 2003 Page #
in addition to the evaluation and management service code used to report the basic service(s). “As you can see, these are code numbers to be used for 'office-based' physicians. CPT Codes 99050;99052:99054		Definitions		

AB1455 Claims Processing Complete Definitions

Including corresponding Rule 1300.71 section, California Code of Regulations (CCR) Title 28.

TERM	Definition
Automatically Definition: (a) (1) Text: (i) & (j)	“Automatically” means the payment of the interest due to the provider within five (5) working days of the payment of the claim without the need for any reminder or request by the provider. If the interest is not sent in the same envelope as the claim payment, the plan or the plan’s capitated provider shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim, and document the specific interest payment made for each claim. In the event that the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, a plan or plan’s capitated provider that pays claims may pay the interest on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid, provided the plan or the plan’s capitated provider includes with the interest payment a statement identifying the specific claims for which the interest is paid, setting forth the method for calculating interest on each claim and

TERM	Definition
	documenting the specific interest payment made for each claim.
Complete Claim Definition: a) (2) Text: (a)(8)(K); (g) & (i)	"Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "reasonably relevant information" as defined in section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and: • For emergency services and care provider claims as defined by section 1371.35(j): ¬ The information specified in section 1371.35(c) of the Health and Safety Code; and ¬ Any state-designated data requirements included in statutes or regulations. • For institutional providers: ¬ The completed UB92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC; ¬ Entries stated as mandatory by NUBC and required by federal statute and regulations; and ¬ Any state-designated data requirements included in statutes or regulations. • For dentists and other professionals providing dental services: ¬ The form and data set approved by the American Dental Association; ¬ Current Dental Terminology (CDT) codes and modifiers; and ¬ Any state-designated data requirements included in statutes or regulations. • For physicians and other professional providers: ¬ The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format; ¬ Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM/ICD-10) codes; ¬ Entries stated as mandatory by NUCC and required by federal statute and regulations; and

TERM	Definition
	¬ Any state-designated data requirements included in statutes or regulations. • For pharmacists: ¬ A universal claim for and data set approved by the National Council on Prescription Drug Programs; and Any state-designated data requirements included in statues or regulations; • For providers not otherwise specified in these regulations: ¬ A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and ¬ Any state-designated data requirements included in statutes or regulations.
Reimbursement of a Claim Definition: (a) (3) Text: (g) (4); (o)(2)(C)	Except as required by section 1300.71.31, "Reimbursement of a claim" means: • For contracted providers with a written contract, including in-network point-of service (POS) and preferred provider organizations (PPO): the agreed upon contract rate; • For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care service rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and • (C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.
Date of Contest Date of Denial or Date of Notice Definition: (a) (4) Text: (b)(1)	"Date of contest, "date of denial" or "date of notice" means the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was

TERM	Definition
	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. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641. (§641 Letter received in ordinary course of mail A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.)
Date of Payment Definition: (a) (5) Text: (b)(1); (b)(5)	Date of payment" means the date of postmark or electronic mark accurately setting forth the date when the payment 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. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641. (§641 Letter received in ordinary course of mail. A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.)
Date of Receipt (Claims Processing) Definition: (a)(6) Text: (c); (c)(1) & (2); (e)(3)(ii); (g); (h) Definition: Rule 1300.71.38(a)	"Date of receipt" means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.
Date of Service Definition: (a)(7) Text: (b)(1); (d)(3)	"Date of service," for the purposes of evaluating claims submission and payment requirements under these regulations, means: • For outpatient services and all emergency services and care: the date upon which the

TERM	Definition
	provider delivered separately billable health care services to the enrollee. • For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a plan and a plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.
Date of Determination Definition: Rule 1300.71.38(a)	"Date of Determination'' means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Department may consider, when auditing the plan's or the plan's capitated provider's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.
Demonstrable and Unjust Payment Pattern or Unfair Payment Pattern Definition: (a)(8) Text: (s)(3); (s)(6)	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): • (A) The imposition of a Claims Filing Deadline inconsistent with section (b)(1) in three (3) or more claims over the course of any three-month period; • (B) The failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) and (B) over the course of any three-month period; • (C) The failure to accept a late claim consistent with section (b)(4) at least 95% of the time for the affected claims over the course of any three-month period; • (D) The failure to request reimbursement of

TERM	Definition
	an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period; • (E) The failure to acknowledge the receipt of at least 95% of claims consistent with section (c) over the course of any three-month period; • (F) The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period; • (G) The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not reasonably relevant, as defined by section (a)(10), for the adjudication of a claim on three (3) or more occasions over the course of any three month period; • (H) 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 payer 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; • (I) 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 reasonable necessary to determine payer 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

TERM	Definition
	claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices; • (J) The failure to include the mandated contractual provisions enumerated in section (e) in three (3) or more of its contracts with either claims processing organizations and/or with plan's capitated providers over the course of any three-month period; • (K) The failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period; • (L) The failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims over the course of any three-month period; • (M) The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required by sections (l) and (o) to three (3) or more contracted providers over the course of any three-month period; • (N) The failure to provide three (3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and Other Required Information consistent with section (m) over the course of any three month period; • (O) Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with section (p) on three (3) or more occasions over the course of any three month period; • (P) The failure 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 over the course of any three-month period; • (Q) The imposition of a provider dispute filing deadline inconsistent with section 1300.71.38(d) in three (3) or more affected claims over the course of any three-month

TERM	Definition
	period; • (R) The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with section 1300.71.38(e) over the course of any three-month period; • (S) The failure to comply with the Time Period for Resolution and Written Determination enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period; and • (T) An attempt to rescind or modify an authorization for health care services after the provider renders 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. (U) A pattern of failure to pay noncontracting individual health professionals the reimbursement described in section 1300.71.31 and required pursuant to section 1371.31 of the Knox-Keene Act for health care services subject to section 1371.9 of the Knox-Keene Act. (V) A pattern of failure to determine the average contracted rate for health care services subject to section 1371.9 of the Knox-Keene Act in a manner consistent with section 1300.71.31.
Interest on the Late Payment of Claims DMHC's "AB 1455" regulations	(1) Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. (2) Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.
Health Maintenance Organization (HMO) Definition: (a) (5) Text: (b)(1); (b)(5) Definition: (a)(9) Text: (g)(1); (h)(1)	"Health Maintenance Organization" or "HMO" means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).
Reasonably Relevant Information Definition: (a)(10) Text:	"Reasonably relevant information'' means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed

TERM	Definition
	services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Information Necessary to Determine Payer Liability Definition: (a)(11) Text: (a)(2); (h)(3)	"Information Necessary to Determine Payer Liability" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Plan Definition: (a)(12)	"Plan" for the purposes of this section means a licensed health care service plan and any contracted claims processing organizations.
Interest on the Late Payment of Claims DMHC's "AB 1455" regulations	(1) Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. (2) Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.
Working Days Definition: (a)(13) Text: (a)(1); (b)(2)(A): (b)(3); (c)(1) & (2); (d)(5); (e)(5); (g); (g)(1) & (2); (h); (h)(1) & (2)	"Working days" means Monday through Friday, excluding recognized federal holidays.
Claim Filing Deadline Definition: (b)(1)	A payer cannot 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. In the event that the payer is not primary under coordination of benefits, a deadline shall not be imposed for submitting supplemental or

TERM	Definition
	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. Less than 3 instances over the course of any 3-month period. Decide favorably for at least 95% of disputes for late claims submission that meet “good cause” explanation.
Claim Forwarding Definition: (b)(2)	Claims involving Emergency Services shall be forwarded to the appropriate payer within 10 Working Days of receipt of the claim. Claims not involving Emergency Services: • If the provider that filed the claim is contracted with the plan’s capitated provider, the plan has 10 Working Days of the receipt of the claim to: ▪ Send the claimant a notice of denial, with instructions to bill the capitated provider, or ▪ Forward the claim to the appropriate capitated provider • In all other cases, the plan has 10 Working Days of the receipt of the claim incorrectly sent to the plan to forward the claim to the appropriate payer. Forward at least 95% of misdirected claims over the course of any 3-month period.
Contracted Provider Dispute Definition: Rule 1300.71.38(a)	“Contracted Provider Dispute’’ means a contracted provider’s written notice to the plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider’s name; the provider’s identification number; contact information; and: (A) If the dispute concerns a claim or a request for reimbursement of an

TERM	Definition
	overpayment of a claim, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; (B) If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and (C) If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.
Non-Contracted Provider Dispute Definition: Rule 1300.71.38(a)	"Non-Contracted Provider Dispute'' means a non-contracted provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name, the provider's identification number, contact information and: (A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect. (B) If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

5.0 REGULATORY REPORTING

5.1 Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department in a single combined document: (A) any emerging patterns of claims payment deficiencies; (B) whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95% of its claims (including the payment of interest and penalties) consistent with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28; and (C) the corrective action that has been undertaken over the preceding two quarters.

5.2 Within 15 days of the close of each calendar year, beginning with the 2004 calendar year, the Plan shall submit to the Director, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report as specified in section 1367(h) of the Health and Safety Code and section 1300.71.38(k) of title 28, in an electronic format (to be supplied by the Department), information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers with each of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. Each Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall include claims payment and dispute resolution data received for the last calendar quarter of the year preceding the reporting year and the first three calendar quarters for the reporting year.(A) The claims payment compliance status portion of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall: (i) be based upon the plan's claims processing organization's and the plan's capitated provider's Quarterly Claims Payment Performance Reports submitted to the plan and upon the audits and other compliance processes of the plan consistent with section 1300.71.38(m) and (ii) include a detailed, informative statement: (1) disclosing any established or documented patterns of claims payment deficiencies, (2) outlining the corrective action that has been undertaken, and (3) explaining how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results). The information provided pursuant to this section shall be submitted with the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant to section 1007 of title 28.

6.0 TRAINING

5.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

7.0 REVIEW PERIOD

6.1 Annually.

8.0 REGULATORY REQUIREMENTS AND REFERENCES

California Health and Safety Code Sections 1367, 1371, 1371.35, 1371.36, 1371.37, 1371.38, and 1371.39

Title 28 California Code of Regulations (CCR) Rule 1300.71

9.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.