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To: Medi-Cal IPAs & IEHP Covered Delegates

From: IEHP – Delegation Oversight

Date: October 23, 2025

Subject: **APL 25-007: Assembly Bill 3275 Guidance - Claim Reimbursement**

On April 1, 2025, the California Department of Managed Health Care (DMHC) released **All Plan Letter 25-007** to provide guidance to health plans on the requirements made by Assembly Bill (AB) 3275 regarding the processing and reimbursement of claims for health care services with a date of receipt on or after **January 1, 2026**.

The following is a preview of the guidance provided, and for further information on APL 25-007, please visit the DMHC website at:

www.dmh.ca.gov > All Plan Letters > 2025 > APL 25-007 – Assembly Bill 3275 Guidance (Claim Reimbursement) or [click here](#).

Guidance on Claim Requirements:

- Must reimburse complete claim within **30 calendar days**.
- If the claim, or a portion of it, is contested or denied, must notify in writing no later than **30 calendar days** from receipt of the claim.
- If the complete claim is not reimbursed within 30 calendar days, interest must accrue at **15% per year** beginning with calendar day 31.
- Must continue to automatically include all accrued interest when making payment on a claim beyond the 30-calendar-day requirement.
- If failure to meet the above interest requirements, must also pay the greater of either an **additional fifteen dollars (\$15)** or **ten percent (10%)** of the accrued interest on the claim. The requirements for interest and penalty apply to all claims, including claims for emergency services and care.
- Must continue to comply with all requirements for claims settlement practices set forth in **Rule 1300.71**, including date of receipt and acknowledgment of claims.
- Must contest or deny a claim, or portion of a claim, **no later than 30 calendar days** after receipt of the claim. Must also notify the claimant, in writing, that the claim is contested or denied.
- If contested, must 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.
- Must not contest a claim that is consistent with codes/services approved by prior authorization with proper documentation.

- 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, reconsideration of the claim must be completed **within 30 calendar days** after receipt of the additional information.
- Requires provider letter used to notify provider the claim/portion of claim is contested/denied (remittance advise).
- Requires updated policies and procedures to reflect all the requirements.

Guidance on Provider Dispute Resolution (PDR) Requirements:

- Must pay interest and penalty on all claim payments not reimbursed within the **30 calendar days** after the date of receipt of a clean claim, including payments from PDR.

Guidance on Grievance Requirements:

- Any complaint from an enrollee about a claim payment delay or denial must be treated as a grievance under the plan's existing grievance process.

For any questions, please contact Jessica Gonzalez, Delegation Oversight Manager, at gonzalez-j6@iehp.org or the IEHP Provider Call Center at (909) 890-2054, (866) 223-4347 or email ProviderServices@iehp.org.

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