SB 1049 – Provider Fair Notice Act
Senator Akilah Weber Pierson, M.D.

SUMMARY

SB 1049 establishes basic fairness and transparency for providers and ensures patients' care is not disrupted by sudden reimbursement challenges by allowing a uniform right for providers to submit a corrected claim within 90 days following a plan's latest action and prohibiting plans from rejecting those corrected claims based on filing deadlines.

BACKGROUND

Health care providers may be denied payment or subjected to overpayment demands based on minor, correctable technical defects—such as coding or documentation errors—even when the underlying service was medically necessary and properly delivered. Current claims-filing deadlines can prevent providers from remedying these defects, resulting in lost reimbursement, administrative waste, and unnecessary disputes that ultimately disrupt patient care.

For example, over the past year, obstetrics practices throughout the state received notices that their obstetric claims were paid incorrectly. Specifically, in April 2025, a Sacramento obstetrics practice received notice from their health plan that 40 previously paid obstetric claims—spanning June 2023 to February 2025—were "paid incorrectly," creating a $90,000 "overpayment." To make up for the overpayment, the plan began recouping funds by withholding payment for ongoing patient care. Many providers were unaware of this coding requirement, which had apparently existed since 2019 but had never been enforced.

PROBLEM

Once the providers learned the error involved a missing diagnostic code, the practice promptly resubmitted corrected claims; however, many of the claims were denied as untimely because the plan's 90-day filing window (which is 90 days from the date of service) had long expired.

While providers in this situation are currently working with the health plan to find recourse, the matter has still yet to be fully resolved. This could have been avoided if providers had been given an opportunity to cure before payment was recouped.

SPECIFICALLY, THIS BILL

Specifically, this bill adds Section 1371.21 to the Health and Safety Code and Section 10123.134 to the Insurance Code to:

- Establish a uniform right for providers to submit a corrected claim within 90 days following a plan's latest action (such as a denial or overpayment notice) if that corrected claim would resolve the issue.
- Prohibit health care service plans from rejecting those corrected claims based on filing deadlines—ensuring fair payment, reducing avoidable conflicts, and promoting efficient claims processing.

SUPPORT

American College of Obstetricians and Gynecologists (ACOG) – Sponsors

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