DEPARTMENT OF INSURANCE

18 **DE Admin. Code** 1310

Statutory Authority: 18 Delaware Code, Sections 311, 2304(16) and 2312
(18 **Del.C.** §§311, 2034(16) and 2312)

PROPOSED

PUBLIC NOTICE

1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80]

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice that a PUBLIC HEARING will be held on Tuesday, June 28, 2005 at 10:00 a.m. in the Consumer Services Hearing Room at the Delaware Department of Insurance, Rodney Building, 841 Silver Lake Blvd., Dover, Delaware. The hearing is to amending **Regulation 1310** relating to **Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services**.

The purpose for amending Regulation 1310 is to speed resolution of health care providers' claims and simplify the current process for resolution of those claims. The proposed amendments provide for a 30 day time period for insurers to process all clean claims and limits the number of times an insurer can request additional information from a provider. The proposed amendment also redefines a clean claim and changes the penalty provisions for violations of the regulation. The hearing officer shall also consider any non-substantive technical changes that may presented at the time of the hearing. This hearing will also consider changes to the proposed regulation resulting from the public hearing conducted by the Department on March 3, 2005.

The hearing will be conducted in accordance with 18 **Del.C.** §311 and the Delaware Administrative Procedures Act, 29 **Del.C**. Chapter 101. Comments are being solicited from any interested party. Comments may be in writing or may be presented orally at the hearing. Written comments, testimony or other written materials concerning the proposed change to the regulation must be received by the Department of Insurance no later than 4:30 p.m., Monday June 27, 2005, and should be addressed to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or email to michael.rich@state.de.us.

1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80]

1.0 Authority

This regulation is adopted by the Commissioner pursuant to 18 **Del.C.** §§311, 2304(16), and 2312. It is promulgated in accordance with 29 **Del.C.** Ch. 101.

7 DE Reg. 100 (7/1/03)

~~**2.0 Definitions**~~

~~2.1 For the purpose of this regulation, the following definitions shall apply:~~

~~**"Carrier" or "Health Insurer"** shall have the same meaning applied to it by **18 Del. C. 3343(a)(1)**.~~

~~**"Clean Claim"** shall mean a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that substantially prevents timely payments from being made on the claim.~~

~~**"Health Care Provider"** shall mean any entity or individual licensed, certified or otherwise permitted by law pursuant to Titles 16 or 24 of the Delaware Code to provide health care services.~~

~~**"Policyholder," "Insured"** or **"Subscriber"** shall be a person covered under a health insurance policy or a representative designated by such person and entitled to make claims on his or her behalf.~~

~~**3.0 Scope**~~

~~This regulation shall apply to all health insurers as defined in Section 2, and shall apply to all plans or policies of health insurance or benefits delivered or issued for delivery in this State and which cover residents of this State or employees of employers located in this State and their dependents. Exempted from the provisions of this regulation are policies of automobile and workers compensation insurance, hospital income and disability income insurance, Medicare supplement and long term care insurance.~~

7 DE Reg. 100 (7/1/03)

4.0 Purpose

The purpose of this regulation is to ensure that health insurers pay claims to policyholders and health care providers in a timely manner. This regulation will establish standards for both determining promptness in settling claims and determining the existence of a general business practice for failing to promptly settle such claims under **18 Del. C. 2304(16)**.

7 DE Reg. 100 (7/1/03)

5.0 Prompt Payment of Claims

5.1 A health insurer shall pay the benefit due under a clean claim to a policyholder or covered person, or make payment to a health care provider no later than 30 calendar days after receipt of clean claim for services.

5.2 A claim is not a clean claim as defined in section 2.2 if any of the following circumstances exist:

5.2.1 Where the obligation of a health insurer to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation for all or part of a claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided.

5.2.2 Where there exists a reasonable basis supported by specific information, available for review by the Department, that such claim was submitted fraudulently.

5.2.3 For claims properly disputed or litigated and subsequently paid.

5.3 In those cases covered by section 5.2.1, a health insurer shall pay all portions of a claim meeting the definition of clean claim in accordance with section 5.1. Additionally, a health insurer shall notify the policyholder in writing within 30 days of the receipt of the claim:

5.3.1 that such carrier is not obligated to pay the claim or make the medical payment, in whole or in part, stating the specific reasons why it is not liable; or

5.3.2 that additional information is needed and is being sought to determine liability to pay the claim or make the health care payment.

5.4 Upon receipt of the information required by section 5.3.2, or upon the administrative resolution of a dispute wherein the health insurer is deemed obligated to pay the benefit due under the claim or make medical payment, a health insurer shall make payment as required by section 5.1.

7 DE Reg. 100 (7/1/03)

6.0 General Business Practice

6.1 Within a 36 month period, three instances of a health insurer's failure to pay a Claim or bill for services promptly, as defined in section 5 above, shall give rise to a rebuttable presumption that the insurer is in violation of 18 **Del.C.** 2304 (16)(f). In determining whether the presumption is rebutted the Commissioner may consider, among other things, whether the health insurer meets nationally recognized timeline standards for claims payments such as those applicable to the Medicare, Medicaid or Federal Employees Health Benefit Plan programs.

6.2 The 36 month time period established in section 6.1 shall be measured based upon the date the claims or bills became due. Each claim or bill, or portion of a claim or bill, pertaining to a single medical treatment or procedure provided to an individual policyholder that is processed in violation of this regulation shall constitute an "instance" as described in section 6.1.

7 DE Reg. 100 (7/1/03)

7.0 Penalties

In addition to the imposition of penalties in accordance with 18 **Del.C.** 2312(b), the Commissioner may order the health insurer to pay to the health care provider or claimant, in full settlement of the claim or bill for health care services, the amount of the claim or bill plus interest at the maximum rate allowable to lenders under 6 **Del.C.** 2301(a). Such interest shall be computed from the date the claim or bill for services first became due.

7 DE Reg. 100 (7/1/03)

8.0 Causes of Action

This regulation shall not create a cause of action for any person or entity, other than the Delaware Insurance Commissioner, against a health insurer or its representative based upon a violation of **18 Del. C. 2304 (16)**.

~~**7 DE Reg. 100 (7/1/03)**~~

~~**9.0 Separability**~~

~~If any provision of this regulation or the application of any such provision to any person or circumstances, shall be held invalid, the remainder of such provisions, and the application of such provision to any person or circumstance other than those as to which it is held invalid, shall not be affected.~~

~~**7 DE Reg. 100 (7/1/03)**~~

~~**10.0 Effective Date**~~

~~This regulation, as amended, shall become effective on August 1, 2003.~~

~~**7 DE Reg. 100 (7/1/03)**~~

2.0 Scope

This regulation shall apply to all carriers as defined herein. Exempted from the provisions of this regulation are policies of insurance that provide coverage for accident-only, credit, Medicaid plans, Medicare supplement plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance or automobile medical payment insurance.

3.0 Definitions

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"Carrier" means any entity that provides health insurance in this State. For the purposes of this regulation, carrier includes a health insurance company, health service corporation, health maintenance organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any 3rd-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

"Days" means calendar days.

"Institutional Provider" means a hospital, nursing home, or any other medical or health-related service facility caring for the sick or injured or providing care or other coverage which may be provided in a health insurance policy. An entity must be a Provider under this Regulation in order to be an Institutional Provider.

"Policyholder," "Insured," or **"Subscriber"** means a person covered under a health insurance policy or a representative (other than a provider) designated by such person and entitled to make claims on his behalf.

"Provider" means any entity or individual licensed, certified, or otherwise permitted by law pursuant to Titles 16 or 24 of the Delaware Code to provide health care services**,** irrespective of whether the entity or the individual is a participating provider pursuant to a written agreement with the carrier. When used alone, the term "provider" shall include individual providers and institutional providers.

4.0 Clean Claim Defined

4.1 A nonelectronic claim by a provider, other than an institutional provider, is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services (CMS) Form 1500 or, if approved by the Commissioner or CMS, a successor to that form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim.

4.2 A nonelectronic claim submitted by an institutional provider is a clean claim if the claim is submitted using the CMS Form UB-92, or, if approved by the Commissioner or CMS, a successor to that form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim.

4.3 An electronic claim by a provider, including an institutional provider, is a clean claim if the claim is submitted using the appropriate ASC X12N 837 format in compliance with the standards specified at 45 CFR §162.1102.

4.4 If allowed by federal law, a carrier and provider may agree by contract to use fewer data elements than are required by the relevant form or format.

4.5 An otherwise clean claim submitted by a provider that includes additional fields, data elements, or other information not required by this Regulation is considered to be a clean claim for the purposes of this Regulation.

4.6 A claim by a policyholder that is submitted in the carrier's standard form using information called for by said forms, with all of the required fields completed, is a clean claim.

4.7 Any claim submitted by a provider or policyholder that includes an unspecified, unclassified or miscellaneous code or data element to constitute a clean claim shall also include appropriate supporting documentation or narrative which explains the unspecified, unclassified or miscellaneous code and describes the

diagnosis and treatment or service rendered.

4.8 A claim for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim is a duplicate cliam and does not constitute a clean claim.

5.0 Means of Submission of Clean Claim

5.1 A provider or policyholder may, as appropriate, make delivery of a claim to a carrier as follows:

5.1.1 mail a claim by United States mail, first class;

5.1.2 submit a claim by delivery service;

5.1.3 submit a claim electronically;

5.1.4 fax a claim; or

5.1.5 hand delivery of a claim.

6.0 Processing of Clean Claim

6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;

6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;

6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.

6.2 The request pursuant to section 6.1.4 must describe with specificity the clinical information requested and relate only to information the carrier can demonstrate is specific to the claim or the claim's related episode of care. A provider is not required to provide information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by the provider whose services are the subject of inquiry. A carrier may make only one request under this subsection in connection with a claim. A carrier who requests information under this subsection shall take action under sections 6.1.2 through 6.1.3 within 15 days of receiving properly requested information.

6.3 A carrier shall be limited to one request on the same claim beyond that provided for in section 6.2 as may be necessary to:

6.3.1 administer a coordination of benefits provision; or

6.3.2 determine whether a claim is a duplicate.

7.0 Unfair Practice

Within a 36 month period, three instances of a carrier's failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 **Del.C.** §2304.

8.0 Interest

The Commissioner may order a carrier found to have violated Section 6 of this Regulation to pay to a provider or policyholder the amount of the claim or bill plus interest at the maximum rate allowable to lenders under Delaware law. Such interest shall be computed from the date the claim or bill for services was first required to be paid. The remedy permitted by this Section is in addition to, and does not supplant, any other remedies available to the Commissioner or the provider.

9.0 Waiver

The provisions of this regulation may not be waived, voided, or nullified by contract.

10.0 Causes of Action

This regulation shall not create a private cause of action for any person or entity, other than the Delaware Insurance Commissioner, against a carrier or its representative based upon a violation of 18 **Del.C.** §2304(16).

11.0 Separability

If any provision of this regulation, or the application of any such provision to any person or circumstances, shall be held invalid, the remainder of such provisions, and the application of such provisions to any person or circumstance other than those as to which it is held invalid, shall not be affected.

12.0 Effective Date

This regulation, as amended shall become effective for all claims submitted for payment on or after November 1, 2005. All claims for payment submitted for payment prior to November 1, 2005 shall be governed by this regulation amended effective August 1, 2003.

8 DE Reg. 1657 (6/1/05)