DEPARTMENT OF INSURANCE
OFFICE OF THE COMMISSIONER
1300 Health Insurance General Provisions

1319 Arbitration of Disputes Between Carriers and Primary Care and Chronic Care Management Providers

1.0 Purpose and Statutory Authority

1.1 The purpose of this regulation is to implement 18 **Del.C.** §§3342B and 3556A, which require health insurance carriers to submit to arbitration any dispute with a provider regarding a carrier's final reimbursement decision for primary care and chronic care management services.

1.2 This regulation is promulgated pursuant to 18 **Del.C.** §§311, 3342B, and 3556A and 29 **Del.C.** Ch. 101. This regulation should not be construed to create any cause of action not otherwise existing at law.

24 DE Reg. 56 (07/01/20)

2.0 Definitions

"**Carrier**" or "**insurance carrier**" means any entity that provides health insurance in this State. "Carrier" includes an 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 third-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

"**Chronic care management**" means the services in the Chronic Care Management Services program, as administered by the Centers for Medicare and Medicaid Services, and includes Current Procedural Terminology ("CPT") codes 99487, 99489, and 99490.

"**Department**" means the Delaware Department of Insurance.

"**Medicare**" means the federal Medicare Program (U.S. Public Law 89-87, as amended) [42 USCS, Ch. 7, XVIII USCS].

"**Primary care**" means health care provided by a primary care provider.

"**Primary care provider**" means any physician or individual licensed under Title 24 of the Delaware Code to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist. Examples of a primary care provider include primary care physicians (including an obstetrician - gynecologist pursuant to 18 **Del.C.** §§3342 and 3556, to the extent that provider is serving in the role as a primary care provider), certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care who provide primary care in a family, pediatrics, internal medicine, or a geriatrics practice.

"**Provider**" means a provider of chronic care management or a primary care provider.

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3.0 Notice of Final Reimbursement Decision

3.1 A carrier shall notify a provider, in writing, of a carrier's final decision regarding reimbursement for an individual claim, procedure or service, if the decision does not authorize reimbursement of the provider's charge in accordance with 18 **Del.C**. §§3342B and 3556A. Such notice may be separate from or a part of the written notice of the carrier's decision.

3.2 Any notice given to a provider pursuant to subsection 3.1 shall:

3.2.1 Be in writing; and

3.2.2 Give the provider notice of the provider's right to arbitration through the Department's arbitration program, by including, at a minimum, the following language:

"You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to a review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information

about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: DOI-arbitration@delaware.gov. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

23 DE Reg. 314 (10/01/19)

4.0 Arbitration Procedures

4.1 Provider Petition for Arbitration.

4.1.1 A provider or a provider's authorized representative may request that the Department review a carrier's final reimbursement decision through arbitration by complying with the following requirements:

4.1.1.1 Complete in full the Department's standard Petition for Arbitration form, which may be downloaded from the Department's website;

4.1.1.2 Attach to the completed Petition for Arbitration all supporting documentation;

4.1.1.3 Include a filing fee in the form of a check that is made payable to the Department of Insurance, which shall be in the amount of $75 and which shall be maintained by the Department in a special fund identified as the "Arbitration Fund";

4.1.1.4 File the original and one copy of the Petition for Arbitration and the appropriate filing fee with the Department, at the following address:

Delaware Department of Insurance
ATTN: Arbitration Secretary
1351 West North Street, Suite 101
Dover, DE 19904

4.1.1.5 Ensure that the Petition for Arbitration is timely submitted so that it is received by the Department no later than 60 days after the provider received the carrier's final reimbursement decision.

4.1.2 A provider who requests Department review under subsection 4.1.1 shall also:

4.1.2.1 Send a copy of the petition and supporting documentation to the carrier by certified mail, return receipt requested; and

4.1.2.2 Deliver to the Department a proof of service confirming that a copy of the petition was sent to the carrier by certified mail, return receipt requested.

4.1.3 The Department may refuse to accept any petition that is not timely filed or does not otherwise meet the criteria for arbitration.

4.2 Carrier Response to Petition for Arbitration

4.2.1 Within 20 days of receipt of the Petition for Arbitration, the carrier shall deliver to the Department an original and one copy of a response to the Petition for Arbitration, to which it shall attach all supporting documents or other evidence.

4.2.2 At the time of delivering the response to the Department, the carrier shall also:

4.2.2.1 Send a copy of the response and supporting documentation to the provider or the provider's authorized representative by first class U.S. mail, postage prepaid;

4.2.2.2 Deliver to the Department a proof of service confirming that a copy of the response was mailed to the health care provider or the health care provider's authorized representative; and

4.2.2.3 Deliver to the Department a $75.00 filing fee, which shall be maintained by the Department in the Arbitration Fund.

4.2.3 The Department may return any non-conforming response to the carrier.

4.3 Appointment of Arbitrator

4.3.1 Upon receipt of a petition filed in proper form, the Department shall assign an arbitrator.

4.3.2 The arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the patient whose care is at issue in the dispute.

4.4 Summary Disposition of Petition by the Arbitrator

4.4.1 An arbitrator may summarily dispose of a petition if:

4.4.1.1 The carrier fails to timely deliver a response; or

4.4.1.2 The arbitrator determines that the petition is meritless on its face or that the subject of the petition is not appropriate for arbitration under this regulation.

4.4.2 If the carrier fails to timely respond to a Petition for Arbitration, the Department may, after verifying proper service and with written notice to the parties, assign the matter to the next scheduled arbitrator for summary disposition.

4.4.2.1 The arbitrator may determine the matter by issuing a default judgment after establishing that the petition is properly supported and was properly served on the carrier.

4.4.2.2 The arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A carrier must make a request for re-opening no later than fifteen days after notice of the default judgment.

4.4.3 If the arbitrator determines that the subject of the petition is not appropriate for arbitration under this regulation or is meritless on its face, the arbitrator may summarily dismiss the petition and provide notice of such dismissal to the parties.

4.5 Arbitration Hearing

4.5.1 The arbitrator shall schedule the matter for a hearing in a timeframe that will allow the arbitrator to render a written decision within 45 days after the delivery to the Department of the Petition for Arbitration. The arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

4.5.2 Testimony at the arbitration hearing is to be limited, to the maximum extent possible, to statements by each party in which they are afforded the opportunity to explain their view of the previously submitted evidence and to answer any questions posed by the arbitrator.

4.5.3 If the arbitrator allows any testimony in addition to that provided for in subsection 4.5.2 of this regulation, the arbitrator shall allow brief cross-examination or other response by the opposing party.

4.5.4 The “Delaware Uniform Rules of Evidence” will be used for general guidance but will not be strictly applied.

4.5.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed to the public.

4.5.6 The arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone, in or outside of the parties' presence, for information the arbitrator deems necessary to resolve the matter.

4.5.7 The arbitrator shall consider the matter based on the submissions of the parties and information otherwise obtained by the arbitrator in accordance with this regulation. The arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

4.6 Arbitrator's Written Decision

4.6.1 The arbitrator shall render the arbitrator’s decision in writing and shall mail a copy of the decision to each of the parties and to the Department within 45 days of the filing of the petition.

4.6.2 If the arbitrator determines that the carrier's final reimbursement decision provides reimbursement to the provider in an insufficient amount, the carrier shall reimburse the provider in the amount that the arbitrator so determines, within 45 days from the date of the arbitrator’s decision.

4.7 Arbitration Costs

4.7.1 The Department shall pay the arbitrator $100 for each arbitration, which shall be payable from the Arbitration Fund.

4.7.2 The arbitrator may award to the health care provider the filing fee, if the health care provider is the prevailing party in the arbitration.

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5.0 Carrier Recordkeeping and Reporting Requirements

5.1 A carrier shall maintain written or electronic records for five years after completion of each arbitration case, documentation of each Petition for Arbitration including, at a minimum, the following information:

5.1.1 The date the petition was filed;

5.1.2 The name and identifying information of the health care provider on whose behalf the petition was filed;

5.1.3 A general description of the reason for the petition; and

5.1.4 The date and description of the arbitration decision or other disposition of the petition.

5.2 A carrier shall file with its annual report to the Department the total number of Petitions for Arbitration filed, with a breakdown showing:

5.2.1 The total number of final reimbursement decisions upheld through arbitration; and

5.2.2 The total number of final reimbursement decisions reversed through arbitration.

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6.0 Non-Retaliation

A carrier shall not terminate or in any way penalize a provider with whom it has a contractual relationship and who exercises the right to file a Petition for Arbitration, solely on the basis of such filing.

7.0 Confidentiality of Health Information

Nothing in this regulation shall supersede any federal or state law or regulation governing the privacy of health information.

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8.0 Computation of Time

8.1 In computing any period of time prescribed or allowed by this regulation, the day of the act or event after which the designated period of time begins to run shall not be included.

8.2 The last day of the period so computed shall be included, unless it is a Saturday or Sunday, or other legal holiday, or other day on which the Department is closed, in which event the period shall run until the end of the next day on which the Department is open.

8.3 When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and other legal holidays shall be excluded in the computation.

8.4 As used in this section, "legal holidays" means those days provided by statute or appointed by the Governor or the Chief Justice of the State of Delaware.

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9.0 Effective Date and Expiration Date

This regulation shall become effective upon adoption and shall expire on August 29, 2021, unless otherwise readopted, with or without amendments. The amendments to this regulation shall become effective July 11, 2020.

22 DE Reg. 605 (01/01/19)

23 DE Reg. 314 (10/01/19)

24 DE Reg. 56 (07/01/20)