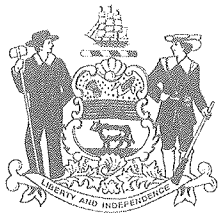
Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

# DOMESTIC/FOREIGN INSURERS BULLETIN NO. 61

**TO:** **ALL CARRIERS WRITING HEALTH INSURANCE IN DELAWARE**

**RE:** **Reminder of Delaware Prompt Pay Provisions**

**DATED:** **February 5, 2013**

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It has come to the attention of the Insurance Commissioner that there have been claim delays occurring due to the application of new CPT coding. The new codes were to be effective as of January 1, 2013.

This Bulletin serves as a reminder that all carriers writing health insurance in Delaware must comply with Delaware's prompt pay provisions contained in Regulation 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services. Failure to comply with Regulation 1310 may result in applicable enforcement actions.

This Bulletin shall be effective immediately.

Karen Weldin Stewart, CIR-ML
Delaware Insurance Commissioner

# 1300 Health Insurance General Provisions

## 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

### 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 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.

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

**9 DE Reg. 242 (8/1/05)**

### 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.

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

**9 DE Reg. 242 (8/1/05)**

### 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 or any successor regulation.

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 claim and does not constitute a clean claim.

**7 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**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.

**7 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**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 6.1.1 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 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**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.

**7 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**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.

**7 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**9.0 Waiver**

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

**7 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**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).

**7 DE Reg. 100 (7/1/03)**
**9 DE Reg. 242 (8/1/05)**

**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.

**9 DE Reg. 242 (8/1/05)**

**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.

**9 DE Reg. 242 (8/1/05)**