**230-RICR-20-30-6**

# TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

## CHAPTER 20 – INSURANCE

## SUBCHAPTER 30– HEALTH INSURANCE

PART 6 – Prompt Processing of Claims

## 6.1 Authority

This Part is promulgated pursuant to R.I. Gen. Laws §§ 27-18-3.2, 27-18-3.3, 27-18-3.4, 27-18-20, 27-18-21, 27-18-46, 27-18-47, 27-18-61, 27-19-30, 27-19-38, 27-19- 39, 27-19-52, 27-20-26, 27-20-33, 27-20-34, 27-20-47, 27-20.1-2, 27-41-19, 27-41-21, 27-41-47, 27-41-48, 27-41-64, 42-14-5, 42-14-16, 42-14-16.1, 42-14-17, 42-14.5-1, 42- 14.5-2, 42-14.5-3 and 42-35-3.

## 6.2 Purpose and Scope

A. This Part is designed to effectuate administration and enforcement of Rhode Island's prompt processing statutes, set out at R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64.

B. This Part, like the state's prompt processing statutes, is very broad in scope. The prompt processing requirements established by R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64 apply to all health insurers, health plans, dental plans, nonprofit hospital and medical service corporations, nonprofit dental service corporations, health maintenance organizations, licensed third party administrators and contractors operating in Rhode Island. These entities and plans are required to process electronic claims submitted by Rhode Island health care providers and policyholders within thirty calendar days from receipt of said claims and to process written claims submitted by Rhode Island health care providers and policyholders within forty calendar days from receipt of said claims.

C. These processing requirements apply to all non-federal program claims, regardless of whether such claims are fully insured or self insured. Examples of federal program claims exempt from this Part include claims submitted for payment under the Medicare program and the Federal Employees Health Benefits program (FEHB). The processing requirements set out in this Part do apply to claims submitted for payment under the RIte Care program, but not to claims submitted under other Medicaid programs.

D. Entities and plans subject to the prompt processing requirement must also:

1. pay interest on claims not paid within the required timeframes,

2. file claims processing reports with the Office of the Health Insurance Commissioner, and

3. provide complete claim standards to participating providers.

E. In addition, this Part establishes a process for Rhode Island providers to file a prompt processing complaint with the Office of the Health Insurance Commissioner.

## 6.3 Definitions

A. As used in this Part:

1. "Affiliate" has the same meaning as set out in the first sentence of R.I. Gen. Laws § 27-35-1(a). An "affiliate" of, or an entity or person "affiliated" with, a specific entity or person, is an entity or person who directly or indirectly through one or more intermediaries controls, or is controlled by, or is under common control with, the entity or person specified.

2. "Claim" means

a. a bill or invoice for covered services,

b. a line item of service, or

c. all services for one patient or subscriber within a bill or invoice.

d. The term "claim" does not include claims for payment under the Medicare program (including claims under Medicare Advantage and Medicare Prescription Drug Plans), FEHB or other federally administered health care programs. The term does, however, include Rite Care program claims, but not other Medicaid program claims.

e. The term "claim" does not distinguish between fully insured and self-insured claims. Both fully insured and self-insured claims are included.

f. The term "claim" includes claims for payment processed on behalf of or for a "subject entity" (defined below) by an agent, contractor, subsidiary, affiliate (as defined by R.I. Gen. Laws § 27-35-1(a)) or any other entity, regardless of whether such claims are:

(1) forwarded to an agent, contractor, subsidiary, or affiliate by a subject entity for processing; or

(2) submitted directly by a health care provider or policyholder to an agent,

(3) contractor, subsidiary, or affiliate of a subject entity for processing.

3. “Commissioner” means the Health Insurance Commissioner.

4. “Complete claim” means

a. a written or electronic claim for payment;

b. submitted by a health care provider or a policyholder;

c. to either

(1) a subject entity or

(2) an agent, contractor, subsidiary, or affiliate of a subject entity; and

d. that meets the written standard defining a complete claim established by the subject entity.

e. For the purposes of this Part, an agent, management company or billing agency may submit a claim on behalf of a health care provider or policyholder.

5. “Contractor” means a person or entity, including a preferred provider organization, that does not offer risk bearing services and only offers services of its network to risk-bearing entities, and a third-party administrator required to be licensed or registered R.I. Gen. Laws Chapter 27-20.7, that:

a. Establishes, operates or maintains a network of participating providers;

b. Contracts with an insurance company, a hospital or medical or dental service plan, an employer, whether underwritten or self insured, an employee organization, or any other entity, including a labor/management trust, providing coverage for health care services to administer a plan; and/or

c. Conducts or arranges for utilization review activities pursuant to R.I. Gen. Laws Chapter 23-17.12.

d. The term “contractor” is not limited to those that have voluntarily registered with the Rhode Island Department of Health.

6. “Date of payment” means the date on which payment is issued by or on behalf of a subject entity. See also the definition of “pay”, “paying”, or “paid” below.

7. “Date of receipt” means the date the subject entity (or an agent, contractor, subsidiary, or affiliate of a subject entity) receives a claim, whether via electronic submission or as a paper claim.

8. “Deny” or “denying” or “denied” or “denial” means a determination by a subject entity (or an agent, contractor, subsidiary, or affiliate of a subject entity) that a claim is not eligible for payment.

9. “Health care entity” means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in R.I. Gen. Laws § 23-17.13-2(2), that operates a health plan. This definition is not limited to Rhode Island licensees.

10. “Health care provider” means an individual clinician, either in practice independently or in a group, who provides health care services in Rhode Island, and is otherwise referred to as a non-institutional provider. A health care provider provides health care services in Rhode Island when that individual, operating independently or through a group, maintains, operates or uses an office, clinic or other place of business in Rhode Island to provide health care services.

11. “Health care services” include, but are not limited to, medical, mental health, substance abuse, dental and any other services covered under the terms of the specific health plan.

12. “Health plan” means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in such plans through:

a. arrangements with selected providers to furnish health care services, and/or

b. financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

13. “Office” or “OHIC” means the Office of the Health Insurance Commissioner.

14. “Operating in this state” means

a. to carry on, conduct or transact any aspect of the processing of a claim in Rhode Island;

b. to be engaged in the business of insurance in Rhode Island;

c. to conduct operations in Rhode Island as a health maintenance organization, nonprofit medical service corporation, nonprofit hospital service corporation, nonprofit dental service corporation, licensed third party administrator or contractor;

d. to offer health insurance in Rhode Island under R.I. Gen. Laws Chapter 27-18;

e. to operate a provider network in Rhode Island for the purpose of the delivery of health care services to health plan enrollees; or

f. to operate in Rhode Island as a health plan certified by OHIC pursuant to R.I. Gen. Laws Chapter 27-18.8.

15. “Pay” or “paying” or “paid” means that a claim payment has been issued by or on behalf of a subject entity. A payment is considered issued on the date payment is made, not on the date it is received. In cases where a claim is processed but a payment is not actually due from a subject entity (e.g., where the amount of the claim is applied to a deductible amount), the claim will be considered paid on the date of final adjudication of the claim, not on the date when notice of the final adjudication is received.

16. “Pend” or “pending” or “pended” means that a determination has been made by a subject entity (or an agent, contractor, subsidiary, or affiliate of a subject entity) that a claim is not complete or is otherwise not immediately payable.

17. “Policyholder” means a person covered under a health plan or a representative designated by such person. “Policyholder” includes those who are usually described in insurance contracts and employee benefit plans as a “subscriber”, “participant”, “member”, “dependent”,

"beneficiary", "policyholder" or other similar term. "Policyholder" does not include any non-person or entity described as "policyholder" in a group contract or agreement.

18. "Process" or "processing" or "processed" refers to the paying, pending or denying of a claim.

19. "Subject entity" means a health care entity operating in this state or a health care entity that operates a health plan in this state.

20. "Substantial compliance" means that the ratio of the number of claims paid or processed by a subject entity within the timeframes set forth in R.I. Gen. Laws §§ 27-18-61(a), 27-19-52(a), 27-20-41(a) or 27-41-64(a) to the number of claims received, is 0.95 or greater.

## 6.4 Prompt Processing of Claims

A. Payment of Claims—Timeframes, Interest and Exceptions

1. A subject entity shall pay all complete claims for health care services submitted to the subject entity by a Rhode Island health care provider or by a Rhode Island policyholder within forty calendar days following the date of receipt of a complete written claim or within thirty calendar days following the date of receipt of a complete electronic claim. When computing the periods of time required for payment of each complete claim by this Part, the date of receipt of the claim shall not be included in the computation of time. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, then the next business day shall be included. As used in this Part, "legal holiday" includes New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Victory Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.

    a. Example 1 - A Rhode Island physician submits a complete written claim by mail to a subject entity on May 1st. The subject entity operates a health plan in Rhode Island and the health plan is certified by OHIC. The subject entity receives the claim on May 3rd. June 12th is forty days from May 3rd. The subject entity has until June 12th to pay the claim. For the purposes of the examples contained in this Part, we assume that none of the processing deadlines falls on a Saturday, Sunday or legal holiday.

    b. Example 2 - A Rhode Island physician submits a complete electronic claim to a subject entity on May 1st. The subject entity

operates a health plan in Rhode Island and the health plan is certified by OHIC. The subject entity receives the claim on May 1st. May 31st is thirty days from May 1st. The subject entity has until May 31st to pay the claim.

c. Example 3 - A Rhode Island physician submits a complete electronic claim to a Rhode Island nonprofit hospital and medical service corporation on May 1st. The claim is received on May 1st. The nonprofit hospital and medical service corporation is a member of the national Blue Cross Blue Shield Association. The claim was submitted for services provided in Rhode Island and the physician who provided the health care services is a participating provider in the plans operated by the nonprofit hospital and medical service corporation. The patient is not insured by the Rhode Island nonprofit hospital and medical service corporation, but instead is insured by an out-of-state Blue Cross Blue Shield Association member. As a member of the national Blue Cross Blue Shield Association, the Rhode Island nonprofit hospital and medical service corporation processes the claim for the insured and makes payment to the physician. This claim is subject to this Part because the claim was submitted by a Rhode Island physician to a subject entity. May 31st is thirty days from May 1st. The Rhode Island nonprofit hospital and medical service corporation has until May 31st to pay the claim.

d. Example 4 - A Massachusetts physician submits an electronic claim to a Rhode Island insurer that operates a health plan in Massachusetts. The health care services were provided to a Massachusetts resident in Massachusetts. This claim is not subject to this Part because the claim was not submitted by a Rhode Island health care provider or by a Rhode Island policyholder.

e. Example 5 - A Rhode Island physician submits an electronic claim to a Massachusetts insurer that operates a health plan in Rhode Island. The health care services were provided in Rhode Island and the physician is a participating provider in the Rhode Island health plan operated by the Massachusetts insurer. This claim is subject to this Part because (i) the claim was submitted by a Rhode Island physician who is a participating provider in the Massachusetts insurer's Rhode Island plan and (ii) was submitted to a subject entity. The Massachusetts insurer is a subject entity because it operates a health plan in this state.

f. Example 6 - A Rhode Island physician submits an electronic claim to a Massachusetts insurer that operates a health plan in Rhode Island. The health care services were provided in Rhode Island, but the physician is not a participating provider in the Rhode Island health plan operated by the Massachusetts insurer. The health care services were not provided within the plan and the claim is an out-of-network claim. This claim is not subject to this Part. The Massachusetts insurer is a subject entity because operates a health plan in this state. Thus, it must process all Rhode Island claims it receives within the timeframes set out in this regulation.

g. Example 7 - An out-of-state physician submits an electronic claim for services provided outside of Rhode Island to a contractor operating in Rhode Island. This claim is not subject to this Part because the claim was not submitted by a Rhode Island health care provider or by a Rhode Island policyholder.

h. Example 8 - A Rhode Island physician submits an electronic claim to a Rhode Island-licensed insurer. The claim is processed by the insurer but is paid using the funds of a self-insured entity. This claim is subject to this Part because the claim was:

(1) submitted by a Rhode Island health care provider, and

(2) was submitted to a subject entity.

i. Example 9 - A Rhode Island physician submits an electronic claim to a Rhode Island- contractor. The claim is processed by the contractor but is paid using the funds of a self-insured entity. This claim is subject to this regulation because the claim was:

(1) submitted by a Rhode Island physician, and

(2) was submitted to a subject entity.

j. Example 10 - A Rhode Island dentist submits a complete written claim by mail to a Rhode Island nonprofit dental service corporation on May 1st. The nonprofit dental service corporation receives the claim on May 3rd. June 12th is forty days from May 3rd. The nonprofit dental service corporation has until June 12th to pay the claim.

k. Example 11 - A Rhode Island dentist submits a complete written claim by mail to a subject entity on May 1st. The subject entity operates a health plan in Rhode Island, the health plan is certified

by OHIC and the health plan provides dental coverage. The subject entity receives the claim on May 3rd. June 12th is forty days from May 3rd. The subject entity has until June 12th to pay the claim.

l. Example 12 - A Rhode Island dentist submits a complete electronic claim to a subject entity on May 1st. The subject entity operates a health plan in Rhode Island, the health plan is certified by OHIC and the health plan provides dental coverage. The subject entity receives the claim on May 1st. May 31st is thirty days from May 1st. The subject entity has until May 31st to pay the claim.

m. Example 13 - A Rhode Island mental health provider submits a complete electronic claim to a subject entity on May 1st. The subject entity operates a health plan in Rhode Island and the health plan is certified by OHIC. The subject entity receives the claim on May 1st and forwards the claim to an out of state contractor for processing. May 31st is thirty days from May 1st. The subject entity is responsible for payment of the claim and has until May 31st to ensure that the claim is paid.

n. Example 14 - A Rhode Island mental health provider submits a complete electronic claim directly to an out of state entity for processing on May 1st. The out of state entity processes the claim on behalf of or for a subject entity operating in Rhode Island. The out of state entity receives the claim on May 1st. May 31st is thirty days from May 1st. The subject entity is responsible for payment of the claim and has until May 31st to ensure that the claim is paid.

2. The subject entity shall pay all complete claims for health care services within the timeframes established by § 6.4(A)(1) of this Part unless an exception set out in § 6.4(A)(3) of this Part applies.

3. Exceptions to the requirements of this Part are as follows:

a. No subject entity shall be in violation of this Part for a claim submitted by a health care provider or policyholder if:

(1) failure to comply with this Part is caused by a directive from a court or federal or state agency;

(2) the subject entity is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(3) compliance by the subject entity is rendered impossible due to matters beyond the subject entity's control and which are not caused by the subject entity.

(4) A subject entity that intends to claim an exemption under § 6.4(A) of this Part must notify the OHIC in writing of its intent to claim an exemption and the facts or circumstances supporting the claimed exemption.

(AA) Example 1 - A Rhode Island physician submits a complete electronic claim to a subject entity. The subject entity, however, is in receivership and is being liquidated. This claim is not subject to the processing timeframes established by this Part.

(BB) Example 2 - A Rhode Island physician submits a complete electronic claim to a subject entity. The subject entity's claim processing system has been damaged by a natural disaster and is temporarily nonfunctional. This claim is not subject to the processing timeframes established by this Part because:

(i) compliance was rendered impossible,

(ii) the damage to the claims processing system was due to matters beyond the subject entity's control and

(iii) the damage to the claims processing system was not caused by the subject entity.

(CC) Example 3 - A Rhode Island physician submits a complete electronic claim to a subject entity on May 1st. The subject entity receives the claim on May 1st. Thereafter, the subject entity's malfunctioning claim processing system "loses" the claim for two months. This claim is subject to the processing timeframes established by this Part. The delay in processing was due to the subject entity's own system failure and was therefore within the control of the subject entity.

b. No subject entity shall be in violation of this Part for any claim

(1) Initially submitted more than ninety days after the health care service is rendered; or

(2) Resubmitted more than ninety days after the date the health care provider received the notice provided for in § 6.4(B) of this Part.

(3) This exception shall not apply in the event that the submission of a claim within the ninety-day period established in § 6.4(A) of this Part is rendered impossible due to matters beyond the control of the health care provider and that were not caused by such health care provider. A health care provider invoking this exception to the ninety-day period must notify the subject entity of

(AA) the matters beyond the control of the health care provider rendered compliance with the ninety-day limits impossible and

(BB) that the noncompliance was not caused by the health care provider. Should a dispute arise regarding provider's reasons for noncompliance with the ninety-day limits, the dispute will be resolved by the OHIC.

c. Examples:

(1) Example 1. A Rhode Island physician submits a complete electronic claim to a subject entity on May 1st. The health care services were rendered on January 1st. This claim is not subject to the processing timeframes established by this Part.

(2) Example 2. A Rhode Island physician submits an electronic claim to a subject entity on May 1st. The subject entity pends the claim on May 5th, notifies the physician in writing of the reasons for pending the claim and provides an explanation of the additional information required to process the claim. On May 15th the physician resubmits the claim electronically. The resubmitted claim is a complete claim. The subject entity receives the claim on May 15th. The resubmitted claim is subject to the processing timeframes established by this Part and must be paid within thirty days of receipt by the subject entity. June 14th is thirty days from

May 15th. The subject entity has until June 14th to pay the claim.

(3) Example 3. A Rhode Island physician submits an electronic claim to a subject entity on May 1st. The subject entity pends the claim on May 5th, notifies the physician in writing of the reasons for pending the claim and provides an explanation of the additional information required to process the claim. On November 1st, the physician resubmits the claim electronically. The resubmitted claim is a complete claim. The resubmitted claim is not subject to the processing timeframes established by this Part because the claim was submitted more than ninety days after the date the physician received written notice from the subject entity regarding the pended claim.

d. No subject entity shall be in violation of this Part while the claim is pending due to a fraud investigation by a state or federal agency.

e. No subject entity shall be obligated under this Part to pay interest to any health care provider or policyholder for any claim if the OHIC has made a finding that such subject entity is in substantial compliance with this Part. This exception to the requirement to pay interest applies only to claims submitted during the period of time specified in the OHIC's order setting forth the finding that the subject entity is in substantial compliance.

f. A subject entity may petition the OHIC for a waiver of the provisions of this Part for a period not to exceed ninety calendar days if the subject entity certifies to the OHIC that it is converting or substantially modifying its claims processing systems and that said conversion or modification process will render it unable to comply with the requirements this Part.

4. A subject entity that fails to pay the health care provider or policyholder after receipt of a complete claim for health care services within the timeframes established by § 6.4(A)(1) of this Part shall pay to the health care provider or the policyholder who submitted such claim, in addition to any reimbursement for health care services provided, interest which shall accrue at the rate of twelve percent per annum commencing on the thirty-first day after receipt of a complete electronic claim or on the forty-first day after receipt of a complete written claim, and ending on the date of payment to the health care provider or the policyholder.

5. The subject entity shall pay the interest required by § 6.4(A)(4) of this Part unless

   a. an exception set out in § 6.4(A)(3) of this Part applies or

   b. the subject entity is deemed by the Commissioner to be in substantial compliance, in accordance with the requirements set out in § 6.6 of this Part, during the period in which the claim is submitted.

B. Denial or Pending of Claims

1. If a subject entity denies or pends a claim, the subject entity shall have thirty calendar days from receipt of the claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim.

2. No subject entity may limit the time period in which additional information may be submitted to complete a claim.

C. Resubmission of Claims

1. Any claim that is resubmitted by a health care provider or policyholder shall be processed by the subject entity pursuant to the provisions of § 6.4(A) and (B) of this Part.

2. Any denied or pended claim for which additional information is submitted by a health care provider or policyholder shall be processed by the subject entity pursuant to the timeframes set forth in § 6.4(A) and (B) of this Part as of the date the additional information was submitted.

## 6.5 Complete Claim Standard

A. Each subject entity operating in this state shall establish a written standard defining a complete claim.

B. Each subject entity operating in this state shall distribute its complete claim standard to all participating providers.

C. Each subject entity operating in this state shall make an initial filing of its complete claim standard with the OHIC within ninety days of January 1, 2007. When filing its initial complete claim standard, an officer of the subject entity must certify that, to the best of his or her knowledge, all participating providers have been provided a copy of the complete claim standard.

D. If a subject entity intends to commence operations in this state after January 1, 2007, the subject entity must make an initial filing of its complete claim standard with the OHIC prior to commencing operations. When filing its initial complete claim standard, an officer of the subject entity must certify that, to the best of his or her knowledge, all participating providers have been provided a copy of the complete claim standard.

E. If a subject entity intends to amend its complete claim standard after filing its initial complete claim standard as required by § 6.5(C) or (D) of this Part, the subject entity shall

1. provide a copy of the amended complete claim standard to participating providers at least thirty calendar days before the effective date of the amended complete claim standard;

2. file the amended complete claim standard with the OHIC at least thirty calendar days before the effective date of the amended complete claim standard; and

3. file a certification by an officer of the subject entity that, to the best of his or her knowledge, all participating providers have been provided a copy of the amended complete claim standard.

F. Examples

1. Example 1. A subject entity operates in Rhode Island as of January 1, 2007. All of the subject entity's participating providers have been provided a copy of the complete claim standard. Within ninety days of the January 1, 2007, the subject entity must file with this Office: a copy of the complete claim standard and a certification by an officer of the subject entity that, to the best of his or her knowledge, all participating providers have been provided a copy of the complete claim standard. Thereafter, unless the subject entity intends to amend or change its complete claim standard, no additional filings are required with respect to the complete claim standard.

2. Example 2. A subject entity plans to begin operations in Rhode Island after January 1, 2007. At least thirty days prior to commencing operations, the subject entity must: provide a copy of the complete claim standard to all network providers, file with this Office a copy of the complete claim standard and file with this Office a certification by an officer of the subject entity that, to the best of his or her knowledge, all participating providers have been provided a copy of the complete claim standard. Thereafter, unless the subject entity intends to amend or change its complete claim

standard, no additional filings are required with respect to the complete claim standard.

3. Example 3. A subject entity operating in Rhode Island makes a timely initial complete claim standard filing after January 1, 2007. Thereafter, the subject entity wants to amend its complete claim standard. At least thirty days prior to the effective date of the amended standard, the subject entity must:

   a. provide a copy of the amended complete claim standard to all network providers,

   b. file with this Office a copy of the amended complete claim standard, and

   c. file with this Office a certification by an officer of the subject entity that, to the best of his or her knowledge, all participating providers have been provided a copy of the amended complete claim standard. Thereafter, unless the subject entity intends to further amend or change its complete claim standard, no additional filings are required with respect to the complete claim standard.

## 6.6 Substantial Compliance

A. All findings of substantial compliance shall be based on calendar year data. Requests for a finding of substantial compliance must be submitted by a subject entity no later than March 1st of the immediately following calendar year. Exemption from the requirement that interest be paid on claims not processed within the timeframes established by § 6.4(A) of this Part will be from the period set forth in the OHIC's order finding substantial compliance and will apply only to claims received by the subject entity during that time period. A finding of substantial compliance is only prospective from the date set forth in the OHIC's order and will not be retroactively applied to claims received by the subject entity prior to that date.

B. A subject entity requesting a finding of substantial compliance under this Part from the OHIC shall submit such supporting documentation as the OHIC may require, including but not limited to

   1. a report in the form promulgated by OHIC in a Bulletin issued for that purpose, certified by either the chief operating officer or the chief financial officer of the subject entity;

   2. claims processing and payment data for the immediately preceding calendar year;

3. a declaration of substantial compliance (e.g., a management representation letter) declaring conformity with the applicable requirements of R.I. Gen. Laws §§ 27-18-61(a), 27-19-52(a), 27-20-41(a), 27-41-64(a) and this Part; and

4. a written report of an independent certified public accountant setting forth an opinion with respect to the accuracy of the representations made in management's declaration of substantial compliance. The OHIC may require additional information and/or may audit, examine or hold hearings as it deems necessary to arrive at a finding as to whether the subject entity is in substantial compliance. The total cost of any audit, examination or hearing held with respect to a request for a finding of substantial compliance shall be borne by the subject entity requesting such finding. The OHIC considers requests for a finding of substantial compliance and any supporting documentation public records under R.I. Gen. Laws § 38-2-1 *et seq*., but only to the extent that the request and supporting documentation do not include personal, identifiable health information.

C. Any professional society representing health care providers, or any individual or groups of health care providers, may notify any subject entity in writing of an interest in receiving any reports and other supporting documentation submitted pursuant to this Part. Any subject entity filing a request for a finding of substantial compliance with the OHIC shall also either contemporaneously send a complete copy of such report and supporting documentation (and any subsequently filed information related thereto) to all professional societies, or any individual or groups of health care providers, which have so notified the subject entity or shall notify such individual or groups by e-mail or mail that a copy of said request and all supporting documentation available on the subject entity's website. The filing with the OHIC shall contain a certification that such notice has been given and shall state the name and addresses of all individuals, groups and entities receiving notice. Any person or entity may provide comment on the filing during a thirty-day public comment period that will begin on the date of the filing of the request with the OHIC. All comments filed will be taken into consideration by the OHIC in evaluating a request for a finding of substantial compliance.

D. A finding of substantial compliance shall be effective for all claims received during the period specified in the OHIC's order finding substantial compliance.

E. If the OHIC determines that the filing does not support a finding of substantial compliance, the OHIC shall notify the entity submitting the filing that its request for a finding of substantial compliance has been denied. Unless an exception applies, a subject entity that has not received a finding of substantial compliance must pay interest on all claims as required by R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20- 47, 27-41-64 and this Part.

F. A finding of substantial compliance does not relieve a subject entity of any of the requirements, obligations or responsibilities of this Part other than the interest payments described in § 6.4(A)(4) of this Part and the reporting requirements of § 6.7 of this Part.

## 6.7 Reporting Requirements

A. A subject entity that does not have a finding of substantial compliance from the OHIC in effect shall submit a report to the OHIC based on the following guidelines:

1. a subject entity that processed, on average, fewer than 10,000 claims per month during the previous calendar year shall, no later than January 31st of the following calendar year, submit a report to the OHIC in the form promulgated by OHIC in a Bulletin issued for that purpose; and

2. a subject entity that processed, on average, 10,000 or more claims per month during the previous calendar year shall, within thirty days following the end of each month, submit a report to the OHIC in the form promulgated by OHIC in a Bulletin issued for that purpose.

B. A subject entity that operates multiple plans in Rhode Island shall aggregate the claims processing data for all of its plans when submitting the report or reports required by § 6.7(A) of this Part.

C. Subject entities that are related, but are separate legal entities (e.g., parent and subsidiary corporations, two corporations with the same parent, etc.), or are otherwise affiliates, shall file separate reports when submitting the report or reports required by § 6.7(A) of this Part.

D. The report or reports required by § 6.7(A) of this Part shall include information related to claims for payment processed on behalf of or for the subject entity by an agent, contractor, subsidiary or any other entity, regardless of whether such claims are:

1. forwarded to the agent, contractor, subsidiary or other entity for processing by the subject entity; or

2. submitted directly to the agent, contractor, subsidiary or other entity for processing by a health care provider or policyholder.

E. Examples

1. Example 1. A subject entity operates a single health plan in Rhode Island. The subject entity processed, on average, 9,500 claims per month during

2006. Because the subject entity processed, on average, fewer than 10,000 claims per month during 2006, the subject entity is not required to submit a monthly prompt processing report during 2007. Instead, the subject entity must file a single annual report no later than January 31, 2008.

2. Example 2. A subject entity operates a single health plan in Rhode Island. That subject entity processed, on average, 10,500 claims per month during 2006. Because the subject entity processed, on average, 10,000 or more claims per month during 2006, the subject entity is required to submit a monthly prompt processing report during 2007. The subject entity must submit each such report within thirty days following the end of each month in 2007.

3. Example 3. A subject entity operates several health plans in Rhode Island. The subject entity processed, on average, a total of 9,500 claims per month during 2006 for all of its plans. Because the subject entity processed, on average, fewer than 10,000 claims per month during 2006, the subject entity is not required to submit a monthly prompt processing report during 2007. Instead, the subject entity must file a single annual report covering all of its plans no later than January 31, 2008.

4. Example 4. A subject entity operates several health plans in Rhode Island. The subject entity processed, on average, a total of 10,500 claims per month during 2006 for all of its plans. Because the subject entity processed, on average, 10,000 or more claims per month during 2006, the subject entity is required to submit a single monthly prompt processing report covering all of its plans during 2007. The subject entity must submit each such report within thirty days following the end of each month in 2007.

5. Example 5. Company A and Company B are two separate, but related subject entities. Company A and Company B each operate several health plans in Rhode Island. Company A processed, on average, 9,500 claims per month during 2006. Company B processed, on average, 10,500 claims per month during 2006. Because Company A processed, on average, fewer than 10,000 claims per month during 2005, Company A is not required to submit a monthly prompt processing report during 2007. Because Company B processed, on average, more than 10,000 claims per month during 2006, Company B is required to submit a single monthly prompt processing report covering all of its plans during 2007. Because each of these companies must file separate reports, Company A must file a single annual report no later than January 31, 2008 and Company B

must submit each monthly report within thirty days following the end of each month in 2007.

6. Example 6. An out of state entity processes mental health claims on behalf of or for a subject entity operating in Rhode Island. Health care providers and policyholders submit mental health claims directly to the out of state entity, not the subject entity. These claims must be included in the subject entity's report required by § 6.7(A) of this Part.

7. Example 7. A subject entity operates several health plans in Rhode Island. The subject entity has contracted with another entity to process all of its claims. Regardless of whether the claims are submitted directly to the subject entity or the contractor, the subject entity must include these claims in its report required by § 6.7(A) of this Part. Under such circumstances, the contractor should not submit a separate report.

F. The report should be submitted to the address specified in § 6.8 of this Part. The OHIC considers reports submitted pursuant to § 6.7 of this Part to be public records under R.I. Gen. Laws § 38-2-1 *et seq*., but only to the extent that a subject entity does not include personal, identifiable health information in the report.

## 6.8 Notification/Reports

A. All reports, notices, complaints or filings required and/or authorized under this Part shall be submitted to the following address:

Office of the Health Insurance Commissioner

1511 Pontiac Avenue

Building #69, First Floor

Cranston, RI 02920

OHIC.HealthInsInq@ohic.ri.gov

## 6.9 Provider Complaint Process

A. A health care provider who alleges a violation of this Part by a subject entity may file a complaint with this Office using the complaint form promulgated by OHIC in a Bulletin issued for that purpose. This Office will not accept written complaints from health care providers unless the procedures established by § 6.9(B) of this Part have been followed.

B. As a prerequisite to filing a complaint with this Office, a health care provider must file the complaint form (promulgated by OHIC in a Bulletin issued for that purpose) directly with the subject entity that is alleged to have violated this Part. The complaint must be mailed to the subject entity by certified or registered mail, with a return receipt requested, or by any other method of delivery that provides a written proof of delivery to the subject entity. If the complaint is not resolved within forty-five days of receipt by the subject entity, the health care provider may file with this Office a copy of the complaint, along with written proof of delivery of the complaint to the subject entity and any written response from the subject entity. The copy of the complaint, the proof of delivery and the written response from the subject entity should be submitted to the address specified in § 6.8 of this Part.

C. The requirements of this § 6.9 of this Part do not apply to complaints by policyholders. Such complaints may be filed directly with this Office.

D. Examples

1. Example 1. A Rhode Island physician submitted the complaint form (promulgated by OHIC in a Bulletin issued for that purpose) to a subject entity by certified mail with return receipt requested. The subject entity signed the return receipt for the complaint on May 1st. As of June 15th, the subject entity had not responded to the physician. The physician may thereafter submit a copy of the complaint and a copy of the return receipt to this Office.

2. Example 2. A Rhode Island physician submits the complaint form (promulgated by OHIC in a Bulletin issued for that purpose) directly to this Office without first submitting the complaint to the subject entity. Because the complaint was not first submitted to the subject entity, this Office will return the complaint to the physician without taking any action on the complaint.

## 6.10 Penalties

A failure to comply with any of the requirements of this Part may result in the imposition of any or all administrative penalties authorized by R.I. Gen. Laws Titles 27 and 42, including R.I. Gen. Laws §§ 42-14-16, § 42-14-16.1, 27-18-3.3, 27-18-20, 27-18-46, 27- 19-39, 27-20-33, 27-41-19, 27-41-21, and 27-41-47.

## 6.11 Judicial Review

Any request for a finding of substantial compliance and decision thereon by the OHIC under this Part or any administrative penalty imposed by the OHIC for a

violation of this Part shall be subject to judicial review pursuant to R.I. Gen. Laws § 42-35-15.

## 6.12 Private Cause of Action

A. A health care provider who alleges a violation of this Part by a subject entity may, in addition to filing a complaint in the manner described in § 6.9 of this Part, bring a civil action for appropriate injunctive relief, actual and punitive damages and costs including reasonable attorney fees.

B. An action commenced pursuant to § 6.12(A) of this Part may be brought in the superior court for the county where the alleged violation occurred, the county where the health care provider resides or the county in which the subject entity maintains its principal place of business.

## 6.13 Severability

If any section, term, or provision of this Part is adjudged invalid for any reason, that judgment shall not affect, impair, or invalidate any remaining section, term, or provision, which shall remain in full force and effect.

**230-RICR-20-30-6**

# TITLE 230 - DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

## CHAPTER 20 - INSURANCE

## SUBCHAPTER 30 - HEALTH INSURANCE

PART 6 - PROMPT PROCESSING OF CLAIMS

Type of Filing: Amendment

**Agency Signature**

E-SIGNED by Elizabeth Tanner — October 23, 2018

Agency Head Signature — Agency Signing Date

**Department of State**

10/11/2018

Regulation Effective Date

K.C. — October 23, 2018

Department of State Initials — Department of State Date