State of Rhode Island and Providence Plantations
DEPARTMENT OF BUSINESS REGULATION
Division of Insurance
233 RICHMOND STREET
PROVIDENCE, RI 02903

INSURANCE REGULATION 102
PROMPT CLAIMS PROCESSING

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Section 1 Authority

This Regulation is promulgated pursuant to R.I. Gen. Laws §§ 42-14-17 and 42-35-3.

Section 2 Purpose and Scope

The purpose of this Regulation is to require Health Care Entities and Health Plans Operating In this State to Process Health Care Claims from Health Care Providers and Policyholders within thirty (30) calendar days from receipt of said Claim and to pay Health Care Providers and Policyholders within thirty (30) calendar days following receipt of a Complete electronic Claim and forty (40) calendar days following receipt of a Complete written Claim from such Provider or Policyholder pursuant to R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64. This Regulation applies to all Health Care Entities and Health Plans Operating In Rhode Island for Claims submitted to such Health Care Entity or Health Plan by Health Care Providers or by Policyholders for Health Care Services rendered in this State to the persons enrolled in such Plans.

Section 3 Definitions

As used in this Regulation:

(a) "Claim" means (i) a bill or invoice for covered services; (ii) a line item of service; or (iii) all services for one patient or subscriber within a bill or invoice, for Health Care Services rendered in this State to persons enrolled in Plans.

(b) "Complete Claim" means a Claim for covered services submitted by a Health Care Provider or a Policyholder which contains all information necessary to Process and Pay such Claim as specified in a Health Plan's published Complete Claim Standard.

(c) "Date of Payment" means the date on which payment is issued by the Health Plan or the date of final adjudication by a Health Plan if no payment is issued.

(d) "Date of Receipt" means the date the Health Plan receives a Claim whether electronic or written.

(e) "Department" means the Department of Business Regulation.

(f) "Denied" or "Denying" means the determination by the Health Plan that a Claim is not eligible for payment because it is not a claim for a covered service or the Claim is for a covered service that was rendered to a person other than a Policyholder.

(g) "Director" means the Director of the Department of Business Regulation.

(h) "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(B), that operates a Health Plan.

(i) "Health Care Provider" or "Provider" means an individual clinician, either in practice independently or in a group, who provides Health Care Services, and is otherwise referred to as a non-institutional provider.

(j) "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.

(k) "Health Plan" or "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:

(i) arrangements with selected Providers to furnish Health Care Services; and/or

(ii) financial incentive for persons enrolled in the Plan to use the participating Providers and procedures provided for by the Health Plan.

(l) "Operating In" means to carry on, conduct or transact any aspect of the processing of a Claim.

(m) "Paid", "Pay" or "Paying" means that a Claim payment has been issued by the Health Care Entity or the final adjudication by a Health Plan has been made if no payment has been issued.

(n) "Pending" or "Pended" means that a determination has been made by a Health Care Entity that a Claim is not complete and a written notification has been issued to the Provider or Policyholder as required by law.

(o) "Policyholder" means a person covered under a Health Plan or Health Care Entity or a representative designated by such person.

(p) "Process" or "Processed" means that a Claim has been Paid, Pended or Denied.

(q) "Substantial Compliance" means that the ratio of the number of Claims paid or processed by a Health Plan or Health Care 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.

Section 4 Prompt Payment of Complete Claims

(a) A Health Care Entity Operating In this state shall Pay all Complete Claims for Health Care Services submitted to a Health Care Entity by a Health Care Provider or by a Policyholder within forty (40) calendar days following the Date of Receipt of a Complete written Claim or within thirty (30) calendar days following the Date of Receipt of a Complete electronic Claim. Each Health Plan shall establish a written standard defining what constitutes a Complete Claim and shall distribute this standard to all participating Providers in accordance with Section 7(a) of this Regulation.

(b) A Health Care Entity which fails to Pay a Complete Claim within the required timeframes shall Pay to the Health Care Provider or the Policyholder who submitted such Claim, in addition to any Payment for Health Care Services, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day following receipt of a Complete electronic Claim or on the forty-first (41st) day following receipt of a Complete written Claim, and ending on the Date of Payment to the Health Care Provider or the Policyholder. The Health Care Entity shall Pay said interest under this Regulation unless an exception as detailed in Section 6 of the Regulation or a finding of Substantial Compliance is applicable to the Claim submitted.

(c) A Health Care Entity or Health Plan Operating In this state shall calculate the time period for payment of each Complete Claim received from a Health Care Provider or from a Policyholder commencing as of the Date of Receipt.

Section 5 Prompt Processing

(a) A Health Care Entity or Health Plan Operating In this state shall Process all Claims submitted by a Health Care Provider or by a Policyholder with 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) and calculate said timeframes from the Date of Receipt of said Claim. If the Claim is not Paid, the

Health Care Entity shall within thirty (30) calendar days of the Date of Receipt notify the Health Care Provider or Policyholder in writing of any and all reasons for Denying or Pending the Claim and what, if any, additional information is required to Process said Claim.

(b) No Health Care Entity or Health Plan may limit the time period in which additional information may be submitted to complete a Claim.

(c) Any Denied or Pended Claim for which additional information is submitted by a Health Care Provider or Policyholder shall be processed by the Health Plan pursuant to the timeframes for Processing and Paying Claims set forth in this Regulation beginning with the Date of Receipt of the additional information.

(d) A Health Care Entity or Health Plan Operating In this state shall calculate the time period for Processing each Claim received from a Health Care Provider or Policyholder from the Date of Receipt until the date the Claim is processed.

Section 6 ***<u>Exceptions to Prompt Processing Requirements</u>***

(a) All Health Care Entities Operating In this State shall Pay interest in accordance with this Regulation on Claims submitted to such Health Care Entity or Health Plan by Health Care Providers or Policyholders for Health Care Services rendered in this State unless a valid exception applies.

(b) Exceptions to the requirements of this Regulation are as follows:

(1) No Health Care Entity or Health Plan Operating In this state shall be in violation of this Regulation for a Claim submitted by a Health Care Provider or Policyholder if:

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

(ii) the Health Care Entity or Health Plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) the Health Care Entity or Health Plan's compliance is rendered impossible due to matters beyond its control and which are not caused by it.

(2) If a Health Care Entity or Health Plan claims an exemption under Section 6(b)(1) above, the Health Care Entity or Health Plan will file documentation supporting its claim of exemption with the Department.

(3) No Health Care Entity or Health Plan Operating In this state shall be in violation of this section for any Claim (i) initially submitted more than ninety (90) days after the Health Care Service is rendered; or (ii) resubmitted more than ninety (90) days after the date the Health Care Provider received the notice provided for

in Section 5(a) of this Regulation. This exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the Health Care Provider which were not caused by such Health Care Provider.

(4) No Health Care Entity or Health Plan Operating In this state shall be in violation of this Regulation while the Claim is Pending due to a fraud investigation by a state or federal agency.

(5) No Health Care Entity or Health Plan Operating In this state shall be obligated under this Regulation to Pay interest to any Health Care Provider or Policyholder for any Claim if the Director has made a finding that such Health Care Entity or Health Care Plan is in Substantial Compliance with this Regulation. This exception to the requirement to pay interest applies only to Claims submitted during the period of time specified in the Director's Order setting forth the finding that the Health Care Entity or Health Care Plan is in Substantial Compliance.

(6) A Health Care Entity or Health Plan may petition the Director for a waiver of the provisions of this Regulation for a period not to exceed ninety (90) calendar days if the Health Care Entity or Health Plan certifies to the Director 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 of R.I. Gen. Laws §§ 27-18-61(a), 27-19-52(a), 27-20-41(a) or 27-41-64(a) and this Regulation.

Section 7 <u>Complete Claim Standard</u>

Each Health Care Entity and Health Plan Operating In this State shall distribute the Complete Claim standard referenced in R.I. Gen. Laws §§ 27-18-61(a), 27-19-52(a), 27-20-41(a) or 27-41-64(a) and Section 4(a) of this Regulation to participating Providers and shall file its Complete Claim standard with the Director annually by January 1. Any changes to the Complete claim standard shall be submitted to the Director and distributed to participating Providers at least thirty (30) calendar days before the effective date of such change.

Section 8 <u>Substantial Compliance</u>

(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 Health Care Entity or Health Plan no later than March 1 of the immediately following calendar year. Exemption from the requirement that interest be paid on Claims not processed 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) will be from the period set forth in the Director's order finding Substantial Compliance and will apply only to Claims received by the Health Care Entity or Health Plan during that time period. A finding of Substantial Compliance is only prospective from the date set forth in the Director's Order and will not be retroactively applied to claims received by the Health Plan prior to that date.

(b) A Health Care Entity or Health Plan requesting a finding of Substantial Compliance under this Regulation from the Director shall submit such supporting documentation as the Director may require, including but not limited to a report in the form attached hereto as Exhibit A certified by either the Chief Operating Officer or the Chief Financial Officer of the Health Care Entity or Health Plan; a Declaration of Substantial Compliance (i.e. 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) or 27-41-64(a) and this Regulation and 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 Director may require additional information and/or may audit, examine or hold hearings as (s)he deems necessary to arrive at a finding as to whether the Health Care Entity or Health Plan 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 entity requesting such finding.

(c) A Request for a finding of Substantial Compliance shall be filed with the Director no later than the March 1 immediately following the calendar year upon which the supporting documentation for the request is based. The supporting documentation and Declaration of Substantial Compliance shall contain Claims Processing and payment data for said immediately preceding calendar year. The Department considers such requests and supporting documentation, to the extent that they do not include personal, identifiable health information, public records under R.I. Gen. Laws § 38-2-1 *et seq*.

(d) Any professional society representing Health Care Providers, or any individual or groups of Health Care Providers, may notify any Health Care Entity or Health Plan in writing of its interest in any receiving any reports and other supporting documentation submitted pursuant to this Regulation. Any Health Care Entity or Health Plan filing a request for a finding of Substantial Compliance with the Department 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 Health Plan 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 Health Care Entity or Health Plans' website. The filing with the Department 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 (30) day public comment period that will begin on the date of the filing of the request with the Department. All comments filed will be taken into consideration by the Director in evaluating a request for a finding of Substantial Compliance.

(e) A finding of Substantial Compliance shall be effective for all Claims received during the period specified in the Director's Order finding Substantial Compliance. If the Order does not specify an expiration date, said finding shall automatically expire at the end of one year.

(f) If the Director determines that the filing does not support a finding of Substantial Compliance, the Director shall notify the entity submitting the filing that its request for a finding of Substantial Compliance has been denied. Unless an exception applies, the Health Plan or Health Care 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 and 27-41-64.

(g) A Health Plan or Health Care Entity which does not have a finding of Substantial Compliance from the Director in effect shall submit monthly reports to the Director within thirty (30) days following the end of each month. The monthly reports shall list the aggregate number of Claims Processed during that reporting period outside of the timeframes specified in R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64 and the amount of interest paid with respect to said Claims. Said report shall be filed in the form appended hereto as Exhibit B.

Section 9 Judicial Review

Any request for a finding of Substantial Compliance and decision thereon by the Director under this Regulation shall be subject to judicial review pursuant to R.I. Gen. Laws § 42-35-15.

Section 10 Severability

If any section, term, or provision of this Regulation 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.

Section 11 Effective Date

This Regulation shall be effective twenty (20) days from the date of filing with the Secretary of State.

EFFECTIVE DATE: October 28, 2003
REPEALED: January 1, 2007

EXHIBIT A

Plan Name

Prompt Claims Processing Act - Measurement of Substantial Compliance

Submitted for Finding for Period: *MMDDYYYY* through *MMDDYYYY*.

		Month Year	Month Year	Month Year	Month Year
A.	Paid Paper Claims				
1	Number of Paper Claims Deemed Complete During Time Period				
2	Number of Complete Paper Claims Paid Within 40 Days				
3	% of Complete Paper Claims Paid Within 40 Days (A.2/A.1)				
B.	Paid Electronic Claims				
1	Number of Electronic Claims Deemed Complete During Time Period				
2	Number of Complete Electronic Claims Paid Within 30 Days				
3	% of Complete Electronic Claims Paid Within 30 Days (B.2/B.1)				
C.	Processed Claims (Denied or Pended)				
1	Number of Claims Processed During Time Period				
2	Number of Claims Processed Within 30 Days				
3	% of Claims Processed Within 30 Days (C.2/C.1)				
D.	Percent of Claims Paid and Processed Within Statutory Timeframes				
1	Number of Complete Paper Claims Paid Within 40 Days				
2	Number of Complete Electronic Claims Paid Within 30 Days				
3	Number of Claims Processed Within 30 Days				
4	Number of Paper Claims Deemed Complete During Time Period				
5	Number of Electronic Claims Deemed Complete During Time Period				
6	Number of Claims Processed During Time Period				
7	Percent of Claims Paid and Processed Within Statutory Timeframes				
E.	**Overall Compliance for Review Period**				

I _____ the _____ if _____ hereby certify that the information contained in this report is true, complete and accurate to the best of my information and belief.

_____ _____

signature date

EXHIBIT B

Plan Name

Interest Paid Report

Month, Year

1. Number of Claims Processed or Paid During Time Period _____

2. Number of Claims Processed or Paid Outside of Timeframes Specified in R.I. General Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64 _____

3. Total Interest Paid for Claims Paid Outside of Timeframes _____

I _____ the _____ if _____ hereby certify that the information contained in this report is true, complete and accurate to the best of my information and belief.

_____ _____

signature date