

NORTH CAROLINA DEPARTMENT OF INSURANCE PROMPT PAY GUIDANCE

**** Updated July 5, 2012 ****

SECTION I. QUESTIONS AS OF July 5, 2012

1. What is the definition of “claimant”? Does “claimant” include the insured?

A “claimant” is any person who files a claim for services, including the insured who received the services or the provider of the services. Such claim is applicable to incurred expenses covered by the insured’s insurance carrier. The claimant’s obligations with respect to claim filing procedures must be followed as stated in the provider contract or in the insured’s group policy or evidence of coverage. *[Refer to G.S. 58-3-225(a)]*

2. With respect to an insurer’s obligation to investigate and take action on a claim within 30 days of receipt, when does the 30 day period begin? The 30 day period is calculated from the day a claim is received by the insurer or the insurer’s claims processor or clearinghouse. There is a statutory presumption that, without evidence to the contrary, the date of receipt is either the day the claim is transmitted electronically, or the fifth business day after it is placed in the U.S. mail. The 30 day time period for taking action on the claim is calculated from the presumed date of receipt, unless the insurer can prove a different date of receipt. *[Refer to G.S. 58-3-225(b)]*

When a provider submits claims through a billing organization, the date the claim is submitted by the billing organization to the insurer is the date from which the presumed receipt date is calculated. If the provider’s billing organization is also the insurer’s claims processor, the 30 day period begins when the claim is received by the claims processing center of the organization

Since receipt date will be established based upon the date of mailing or electronic submission, it will be incumbent upon health care providers and/or their billing organizations to document the date claims are mailed or electronically transmitted to the insurer or the insurer’s claims processor. Such documentation will be vital in resolving disputes regarding claim payment processing times.

3. What constitutes sufficient evidence for rebuttal of the presumed date of receipt of a claim? The statute establishes a presumption that a claim is received by the insurer five business days after it is placed in the U.S. mail, or on the day it is transmitted electronically to the insurer’s designated clearinghouse. The Department anticipates that in most instances it will be very difficult, if not impossible, for an insurer to successfully rebut this presumption, especially when it contends the claim was never received. Some examples of evidence that a claim was not received at all, or was not received on the presumed date, might include the following *(These are examples only and are not assumed to provide sufficient evidence to rebut the presumption in all cases)*:

- The envelope accompanying the claim is clearly postmarked after the date the claim was presumed to have been received.
- The envelope accompanying the claim shows evidence of an incorrect or incomplete mailing address or insufficient postage.
- The provider utilizes a billing service that is unable to substantiate either that a claim was submitted at all, or the date that it was submitted to the insurer.
- Proof that the U.S. mail was not delivered on the date the claim was presumed to have been received.
- Information on the claim itself or accompanying the claim, indicating that it could not have been submitted on the presumed date.

In addition to the examples above, an insurer’s date stamps, logs, or the verifiable mail room and claims handling procedures may provide sufficient evidence of the general claims handling practices of the insurer, but may or may not suffice as evidence of the receipt or non-receipt of an individual claim. The Department expects that providers and insurers will exercise reasonable judgment in resolving individual cases.

In cases involving Department review, the parties should generally expect a high standard of proof will be necessary to establish an insurer's legitimate rebuttal of the presumed date a claim was received. In conjunction with that expectation, claimants will be expected to present reasonable evidence of the date the claim was mailed, transmitted electronically or otherwise delivered to the insurer.

The Managed Care and Health Benefits Division is considering development of a "Prompt Pay Complaint Form" for health care providers to use when they wish to file a complaint with the Department.

4. When is payment considered to have been made? Payment is considered made on the date it is placed in the U.S. mail, or on the date of electronic transfer or other delivery of funds to the claimant. The Department recognizes that the date a check is written may not be the date of payment, as defined in the statute. In order to show compliance with this law, insurers will be required to maintain a record of the date of mailing or electronic transfer of funds. *[Refer to G.S. 58-3-225(e)]*

5. Must the explanation of payment or Remittance Advice (RA) be mailed along with the claim payment? When the claimant is the insured, G.S. 58-63-15(11)(j) requires that payment of a claim be accompanied by a statement setting forth the coverage under which payment is being made. The law does not establish any requirement with respect to whether the payment and the RA must be sent together when the claimant is a provider.

6. When an insurer is contracting with an intermediary, does the insurer's payment to the intermediary satisfy the law if it is made within statutory time frames, regardless of when the actual provider is paid? When an insurer contracts with an intermediary that is acting as the provider's agent, and the contract calls for payments to be made to the intermediary, the statutory time frames apply only to the insurer's payment to the intermediary. The timing of subsequent payment by the intermediary to the provider is not subject to the prompt pay law.

7. When a claimant inquires about a claim older than 30 days, for which no payment, denial, or request for additional information has been received, will the insurer be required to acknowledge the inquiry in writing? The law does not require written acknowledgment of such inquiries, however both the insurer and the claimant are strongly advised to maintain written documentation of such communications*, in the event that one or both parties wishes to seek the Department's review of a matter. Claimants who follow their telephoned inquiries to insurers with written confirmation of the call, will have established documentation, regardless of whether the insurer responds to the inquiry in writing. Any potential action or investigation by the Department of complaints regarding the prompt pay law will largely depend upon a written or electronic record of the matter in question.

** Note that while insurers are not required to acknowledge provider inquiries, they are subject to the requirement of G.S. 58-3-225(i), which calls for insurers to maintain written or electronic records sufficient to demonstrate compliance with the law.*

8. How will the 30 day claims processing time standard apply to claims resulting from appeals and grievances? If an appeal or grievance decision results in the insurer reversing its denial of a claim, the 30 day time period for processing the claim would begin from the date of the appeal or grievance decision.

9. If the provider contract calls for something other than a 180 day limit for submitting claim information, does the contract have to be amended, or does the law supersede the contract? As of July 1, 2001, insurers must be in operational compliance with the law, including the 180 day minimum time period for submitting claims set out in G.S. 58-3-225(f), regardless of existing contract language. In-force provider contracts that are more restrictive (allow less than 180 days) than the law will be superseded by the law. In-force provider contracts that are less restrictive (allow more than 180 days) than the law will remain in effect unless amended. New provider contracts executed on or after July 1, 2001 must be compliant with the prompt pay law. A contract that allows more than 180 days to submit claims is compliant with the law.

Amendments regarding claims submission time frames are not considered to be “material” modifications to provider contracts, pursuant to 11 NCAC 20.0203, and therefore are not subject to Department approval. However, if/when an insurer makes a material modification to a contract, it must also make any necessary modifications to comply with the prompt pay law at that time, including changing the time to submit the claim to at least 180 days.

10. Are there cases when a claimant would be permitted to file a claim in more than 180 days (or longer than the contractually allowed time, if that is more than 180 days)? * SEE CORRECTION LISTED IN SECTION II OF THIS DOCUMENT *****

G.S. 58-3-225(f) provides that unless otherwise agreed to by the insurer and the claimant, insurers must allow a claim to be submitted up to one year after the required date of submission (i.e., 180 days after the date of service or discharge plus one year), if it was not reasonably possible for the claim to be submitted within 180 days, and if the claim was submitted as soon as possible thereafter. Force majeure is assumed to be the standard for a provider’s reasonable inability to file a claim within the established time frame, though contracts may include provisions establishing more generous standards. When the claimant is the insured, legal incapacity could extend the filing time beyond the one year extension. *[Refer to G.S. 58-3-225(f)]*

11. May insurers pend or deny claims for lack of coordination of benefits (COB) information?

G.S. 58-3-225(b)(5) clearly allows insurers to obtain COB information prior to paying a claim. An insurer is not obligated to make a payment to the provider or insured until it has established its liability, and COB information can be material to that determination. Insurers routinely verify third party coverage at the time a claim is filed since such coverage can change at any time, without any notice to the insurer.

12. What are “good faith” reasons for denying claims and what standards can insurers impose for completeness and accuracy of claims? Can insurers correct or complete the submissions rather than requiring the claimant to do so? An insurer is not obligated to pay a claim until it has determined satisfactory proof of loss and this fact is not changed by the prompt pay law. The law does require insurers to be very explicit in their requests for additional information, however, their right to request that information is not altered. All of the specific good faith reasons for denial must be reflected in the notice of denial or request for additional information. In cases where the claimant provides additional information but the information is insufficient or incorrect, the insurer may deny the claim, again itemizing the information lacking. *[Refer to G.S. 58-3-225(b),(c) and (d)]*

Since this law does not attempt to define “clean claim”, the Department is not in a position to itemize information that may not be required in accordance with an insurer’s standard claim practices. Each insurer must comply with the uniform claim form requirement of 11 NCAC 12.1500 and the electronic format standards requirements of 11 NCAC 12.1506. In addition, required attachments to claim forms are permitted, however, the form and format must be approved by the Department and insurers may not require the submission of information already contained in the standard claim form.

Finally, under federal HIPPA regulations, currently scheduled to become effective January 1, 2003, an insurer is prohibited from altering the form on which the original claim was submitted.

Consequently, insurers will not be permitted to correct or supply information to the original form once those regulations are in effect.

13. When a claimant submits additional information at the request of the insurer, and the additional information is incorrect or leads to further questions, can the insurer make a second request for additional information? The law requires that a claim shall be paid, denied or additional information requested within 30 days after it is received. Within 30 days after receiving additional information, the insurer shall continue processing the claim and either pay or deny the claim. *[Refer to G.S. 58-3-225(c)]* If the additional information requested by the insurer is not sufficient for the insurer to establish proof of loss, the insurer must deny the claim and include in the notice all of the good faith reasons for denial. If the claimant subsequently resubmits the claim with the necessary information, within 180 days of the date of service, the insurer shall reopen the claim. *[Refer to G.S. 58-3-225(f)]* A claim must be closed if additional information has been requested but is not received within 90 days of the request. In that instance, G.S. 58-3-225(d) provides that the notice to the claimant must specify that the claim will be reopened if the information previously requested is submitted within one year of the denial notice closing the claim.

14. If an insurer knows in advance that it cannot meet the 30-day claims processing requirement (e.g., during periods of heavy claims volume), and notices are sent to claimants, advising of the expected delay and assuring payment with appropriate interest, will this be viewed by the Department as a “good faith” attempt to comply with the law? No. When an insurer can anticipate heavy claims volume at certain times of the year, based upon past experience, the Department expects that all reasonable steps will be taken to accommodate these fluctuations. Acknowledging non-compliance with the law does not exempt an insurer from potential sanctions. Refer to the answer to question number 26 for a more complete discussion of sanctions for violations of the prompt pay law.

15. How much information can be shared with the patient by the provider or the insurer when the patient’s employer has not paid the premium? How much information must the insurer share with the provider when the employer has not paid the premium or the payment has not yet been processed?

G.S. 58-3-225(b) clearly recognizes that insurers may deny or pend claims due to unpaid premiums. The prompt pay law does not prevent providers or insurers from informing insureds (when the insured is not the claimant) of non-payment of premium by an employer group.

North Carolina law requires a minimum grace period for payment of premiums. (Ten days for policies with monthly premiums and 31 days for premiums due less frequently.) If a claim is filed for services rendered after premium payment had lapsed, but during the grace period, the insurer may notify the claimant that the claim is pending additional information from the group. If services were rendered during a period that premiums were unpaid, and after the grace period had expired, then the patient was not insured at the time of service and the provider has the right to bill the patient for services. The claim denial notice in such a case must specifically reference the lapse in coverage. *[Refer to G.S. 58-3-225(c)]*

North Carolina regulations require insurers’ provider contracts to contain a provision for providers to verify an insured’s eligibility before services are rendered, based upon the latest information available to the insurer. The regulation, 11 NCAC 20.0202(10), also specifies that provider contracts may contain provisions for the treatment of incorrect eligibility information and retroactive terminations due to incorrect or late information given to the insurer by an employer group.

16. In cases where the insurer suspects a claim is fraudulent, must the notice use the word “fraud” or can other terminology be used to avoid charges of slander? Notices to the claimant and to the insured during the period of investigation of a suspected fraudulent claim may be worded in accordance with the advice of the insurer’s legal counsel. *[Refer to G.S. 58-3-225(k)]*

- 17. May insurers request missing information directly from an insured when the insured is not the claimant? Must the insurer notify the insured of missing information when the insured is not the claimant?** The law requires only that the claimant be notified of the need for missing information. If the insurer chooses to request information directly from the insured, the notice to the claimant of the reason the claim cannot be paid must also inform the claimant that the insured has been asked to provide missing information. *[Refer to G.S. 58-3-225(b)]*
- 18. What “specific clinical rationale” will be required if the claim is denied?** If all or part of a claim is denied because of a utilization management or medical necessity standard, the specific clinical rationale for the denial, including reference to the pertinent clinical review criteria that was applied in review of the claim must be provided. “Clinical review criteria” is defined in G.S. 58-50-61(a)(2). The Department expects the notice to contain sufficient pertinent detail to inform the claimant of the insurer’s reasoning, based upon the specific facts of the case. The notice must also include information on how to request the clinical review criteria used in evaluating the claim.
- If the specific clinical rationale has already been provided in a noncertification notice under G.S. 5850-61(h), then the insurer is not required to repeat that information in the claim denial notice, but may instead make reference to the previous noncertification notice. In cases where the specific clinical rationale has not been provided previously, the denial notice must include the clinical rationale as described above. *[Refer to G.S. 58-3-225(c)]*
- 19. Are insurers required to report interest payments separately on the Remittance Advice and identify the associated claim?** Although there is no specific requirement as to the reporting of interest payments, insurers must be able to demonstrate their compliance with the statute, including the payment of interest on claims not paid within statutory time frames. In order to demonstrate compliance, it will be necessary for insurers to provide sufficient detail for each claim where interest is owed, including the amount of interest owed and the time period for which it was paid. Thus, the reporting of interest on an individual claim basis should be a byproduct of this requirement, however, there may be more than one way for an insurer to fulfill the requirement.
- 20. Is the insurer to pay interest automatically, or is the claimant to request the interest? Can a provider invoice the insurer for the amount of interest owed?** Insurers are required to automatically pay interest on claims not paid within statutory time frames, without placing the burden of requesting interest payment on the claimant. In order to demonstrate compliance with the law, insurers must maintain individual claim records showing the interest paid for each claim that is subject to an interest payment. Provider invoices cannot be a substitute for an insurer’s automatic calculation and payment of interest, or for an insurer’s record of interest paid on each claim where interest was due. The law does not prevent a mutual agreement between a provider and an insurer for a periodic reconciliation of interest payments made by the insurer, compared to the provider’s own calculation of interest due.
- 21. If partial payment is made within the statutory time frames and only part of the claim is paid late, is interest due only on the portion of the claim that is paid late, or on the whole claim?** Interest is due only on the portion of a claim that is not paid within the time frame established in the law.
- 22. In cases where the insurer did not believe that interest was due and did not pay it, but the claimant demonstrates that interest should have been paid, when would interest start/stop accruing?** Interest would start accruing on the date that payment should have been made (i.e., 30 days after receipt of adequate proof of loss) and would stop accruing on the date the payment was made.

- 23. What if the payment amount was less than it should have been? Is interest owed on the amount underpaid?** Where there is no provider contract or where the subject is not addressed in the provider contract, the insurer is required to pay claims in accordance with the insurance contract. Insurers must make adjusted payments when the initial payment was less than it should have been, with interest due on the amount that was underpaid. Contracts between insurers and providers may specify the conditions and circumstances under which corrections to underpayments are subject to interest. *[Refer to G.S. 58-3-225(h)]*
- 24. Must the provider pay interest to the insurer when returning overpayments and if so, when would the interest begin to accrue?** The prompt pay law does not require providers to pay interest on overpayments being returned to the insurer. Rather, it states that recoveries are to be made pursuant to contracts between insurers and providers and that the contracts may specify whether interest is to be paid on overpayments. However, if the insurer had originally paid interest on the overpayment amount, then the insurer may request a refund of the interest along with the overpayment. When recouping overpayments, insurers must give sufficient detail so that providers can identify the specific claim against which the recoupment is being made. *[Refer to G.S. 58-3-225(h)]*
- 25. Is there a time limit for recoupment of overpayments?** The Prompt Pay Law states that insurers' recoveries of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor. *[Refer to G.S. 58-3-225(h)]* **[updated July 5, 2012]**
- 26. Is the insurer subject to sanctions for all late payments?** No. G.S. 58-3-225(j) provides that if the insurer has paid interest "in good faith" along with payment of the claim, no additional sanctions for that late payment are called for in the law. In addition, G.S. 58-3-225(k) provides that insurers are not in violation of the law if their failure to pay a claim is due to "matters beyond the insurer's reasonable control" or if the insurer has a "reasonable basis to believe" the claim is fraudulent and the claimant is notified accordingly.

An insurer is subject to the sanctions in G.S. 58-2-70, if the Department establishes that the insurer has violated the law. Examples of violations of the law would include an established pattern or practice of failure to make required interest payments, or an excessive number of late payments, even where interest is paid, or systematic delays in making payments after claims have been processed and approved for payment.

Regardless of whether penalties are likely to apply, insurers are expected to pay claims timely as a general practice and to pay interest promptly on claims paid late. Although providers should not expect the Department to intervene in every dispute over individual claims, the Department will continuously monitor filed complaints, in order to evaluate whether such patterns or practices potentially exist.

- 27. When must a claim status report be sent to the insured?** A claim status report must be sent to the insured if a claim submitted by a provider has not been paid or denied 60 days after the date of initial receipt, unless the insurer is awaiting information it has requested from the provider. A claim status report is not required during the period of time the insurer is awaiting requested information. Upon receipt of the requested information, a claim status report must be sent to the insured indicating that the claim is under review. A copy of this initial report need not be sent to the provider. If the claim remains unresolved 30 days after the first claim status report, another claim status report must be sent to the insured and a copy to the provider. Claim status reports must be sent to the insured and to the provider every 30 days while the claim remains unresolved. In the event additional information has been requested but not received within 90 days of the request, the insurer must deny the claim and provide notice to the claimant. *[Refer to G.S. 58-3-225(d) and (g)]*

- 28. Does the 45-day notice of unpaid claims, required under 11 NCAC 4.0319(5), apply to claims subject to the prompt pay law?** No. The claim status report required at 60 days replaces the 45-day notice requirement. The 45-day notice under 11 NCAC 4.0319 would only be applicable to business exempt from the prompt pay statutes, such as claims under Medicare supplement and long-term care plans.
- 29. Are electronic records acceptable? If so, will insurers have to maintain stagnant fields to show interim communications with claimants?** Insurers may maintain all of their records in electronic format. Records documenting compliance with all aspects of the law are required. This would mean, for example, that a field containing the date a claim was received could not be overwritten by the date additional information was received, unless a record of that date is maintained elsewhere. *[Refer to G.S. 58-3-225(i)]*
- 30. Does the exclusion of long-term or nursing home care under G.S. 58-3-225(1)(a) apply to coverage of skilled nursing services when those are included in a benefit plan?** A stand-alone long-term care insurance carrier is exempt from the definition of benefit plan. Claims for nursing home services within an otherwise eligible plan shall comply with the law.
- 31. Is a TPA administering claims for an insured plan subject to the prompt pay law?** A TPA is not directly subject to the law, however the insurer contracting with the TPA is subject to the law. The insurer employing the services of a TPA must stipulate that the TPA will administer claims according to state insurance laws, and the insurer will remain liable for any failure of the TPA to comply. The responsibilities of the TPA as to any of these matters shall be set forth in the agreement between the TPA and the insurer.
- 32. Does the prompt pay law apply when a TPA is administering for a self-funded plan?** An employee benefit plan established by an employer pursuant to the Employee Retirement Income Security Act (ERISA) of 1974 is not subject to State insurance laws, due to federal preemption. Thus, a self-funded plan is subject to federal regulations under ERISA, with respect to claim payments, and North Carolina's prompt pay law does not apply.
- 33. How are providers to know who the insurer is and whether the group is fully or self-insured?** At the time service is rendered, the provider has an opportunity to collect, update or reconfirm patient information, including a copy of the patient's health insurance card. State law cannot dictate the information to be included on ID cards for self-funded plans. Therefore, insured status may not be clear, especially if the plan is administered by an insurance company or an HMO. However, the plan administrator should confirm self-funded status upon inquiry by the claimant. The Department acknowledges that this situation can pose problems for providers.
- 34. Are MEWAs subject to the prompt pay law? MEWAs are not protected by a guaranty association and sanctions might threaten the solvency of their operations.** North Carolina-licensed MEWAs are subject to the prompt pay law. The prompt pay law does not make any special allowances for North Carolina-licensed MEWAs, with respect to sanctions and/or interest payments related to "prompt pay" violations. The law would not preclude MEWAs from protecting their finances by making their claims administrators contractually responsible for such amounts, in instances of non-compliant claims processing performance.
- 35. How will the provisions of the prompt pay law affect plans that are administered by North Carolina insurers, but that are underwritten out of state?** If the North Carolina insurer is merely administering a health plan underwritten and validly issued out of state by another insurer and is not assuming any risk under that contract, North Carolina insurance laws, including prompt payment law, would not apply to those contracts.

36. What impact do Federal ERISA Claim Rules have on the provisions of the prompt pay law? A brief comparison of provisions for decisions on post-service claims is as follows: Time within which to file a claim: *Federal Rules* – Rules are silent on how long a claimant has to file a claim from the date of service. *State Law* – Law permits insurers to limit the time for submission of claims to 180 days, which can be extended in the event of legal incapacity of the insured claimant.

Time within which to pay a claim: *Federal Rules* – Rules require claims to be paid within 30 days of receipt of the claim, which may be extended up to an additional 15 days for matters beyond administrator's control. For extensions due to failure of the claimant to submit necessary information, the claimant is given 45 days from receipt of the notice to provide the requested information. *State Law* – Law requires claims to be paid within 30 days of receipt of the claim. If additional information is requested, the claim must be paid 30 days from receipt of the information. If requested information not received within 90 days, the insurer must deny the claim.

Based on conversations with the US Department of Labor (US DOL), it appears that certain provisions of North Carolina's prompt pay law may conflict with the ERISA Claim Rules regarding the time allowed to process a claim in those cases where additional information is necessary to process the claim. Specifically, allowing up to 30 days to review the initial claim plus up to 30 days more to review the additional information requested may exceed what appears to be a single 30-day period for decision allowed in the federal rule. The Department will proceed with requesting a formal advisory opinion from the US DOL and will issue an update on this matter. In addition, we will consider pursuing appropriate legislation amending our law to conform to the federal rule. Meanwhile, insurers should keep in mind that, regardless of whether North Carolina laws are amended, they will need to comply with the federal rules when they go into effect on January 1, 2002.

The Department is still analyzing the federal regulations with respect to North Carolina laws that apply to utilization review, appeals and grievances.

37. Will the Department require insurers to report on their claim payments? The law does not establish a requirement for regular reporting on claims processed, but the Department may require special reports to evaluate compliance with the law. Although definite plans do not exist at this time, it is very likely that the Department will evaluate compliance with this law some time in 2002. In addition, insurers will be required to make claim payment data available during their market conduct examinations.

38. When must insurers that qualify for delayed compliance with the law be in full compliance?

***** SEE UPDATE LISTED IN SECTION II OF THIS DOCUMENT *****

Insurers that qualify for delayed compliance will be subject to the law when their new claims processing systems are implemented, beginning as claims are entered into the new system. However, whether or not the new system is fully implemented, the company must be in full compliance for all claims received on or after January 1, 2003.

Following is an update on the insurers that have asserted eligibility for delayed compliance:

Connecticut General Life Insurance Company (CGLIC) CGLIC, a CIGNA affiliate, has two claim systems that qualify for delayed compliance. CGLIC's indemnity, preferred provider and dental claims are currently processed on the CIGNA-Claim adjudication system. Some CGLIC indemnity and preferred provider claims are also processed on the Medicom claims system. The CIGNA-Claims system was implemented in April 1979 and the Medicom System in October 1981. CGLIC plans to migrate all business to a new claims adjudication system with a target date of 1st quarter 2002. 35,269 (13%) of CGLIC's covered lives in North Carolina are supported by one of the old claim systems.

Blue Cross & Blue Shield North Carolina (BCBSNC) All of BCBSNC products, both group and individual, are currently adjudicated using the "legacy" system, except for BCBSNC's newest group products: Blue Options (PPO), Blue Choice (POS), Classic Blue (CMM), and Blue Care (HMO). BCBSNC's "legacy" system, also known as LRHP, was implemented prior to 1982. Group business is being converted to the new products supported by a new claims system as each group renews. Given existing renewal dates, all groups would be converted to a new product and would be in compliance with the prompt pay law, by July 2002. It is possible that some groups will remain on the LRHP system, and changes will be made to bring that system into compliance with the law not later than December 31, 2002. Individual business will be brought into compliance by December 31, 2001, either by moving that business to the new claims system or by modifying the LRHP system. As of December 31, 2000, 524,075 (96%) of total insured lives were covered under a product supported by the legacy system. Of the 524,075 lives, 345,767 are covered under group and 169,308 are covered under individual policies.

Both companies have been asked to provide the Department with quarterly updates on the number of lives and the percentage of business impacted by these older systems and status reports of progress made. Additionally, they have been informed to maintain all records processed on the older systems for future audits by the Department.

- 39. Will the Department publish information regarding the effects of the prompt pay law?** The Department does expect to report on the effects of the law when sufficient experience-based information becomes available. Insurers' compliance with the prompt pay law will be evaluated during market conduct examinations and those findings will be included in final examination reports.
- 40. How shall insurers account for the expense of interest payments in rate development and financial reporting?** Interest expenses are to be classified as administrative and not medical expenses for these purposes.
- 41. Do references in the prompt pay law to a number of days, mean calendar days or business days?** Subsection (b) of G.S. 58-3-225 refers to "business days" for purposes of determining the presumed date of receipt of a claim that has been mailed and "calendar days" for action to be taken by the insurer. Unless otherwise specified in the law, the number of days within which some action must be taken refers to calendar days. If the referenced calendar day falls on a weekend or a holiday, then the first business day following that day will be considered the date the required action must be taken.
- 42. Will insurers be required to report interest payments to claimants for tax purposes, and will claimants be required to report interest as income?** The Department is not qualified to give tax advice, and is not responsible for verifying compliance with tax laws. Insurers should contact the IRS or seek professional advice concerning their obligations to issue 1099INT forms to claimants who were paid interest. Upon inquiry to the NC Department of Revenue, we were advised that interest income generally is reportable, regardless of whether a 1099INT form was issued. However, providers are advised to contact the IRS or seek professional advice regarding their tax obligations for interest income.

SECTION II. CHANGES & UPDATES TO ITEMS ADDRESSED ON FEBRUARY 21, 2001

Regarding:

- 10. Are there cases when a claimant would be permitted to file a claim in more than 180 days (or longer than the contractually allowed time, if that is more than 180 days)?**
G.S. 58-3-225(f) provides that unless otherwise agreed to by the insurer and the claimant, insurers must allow a claim to be submitted up to one year after the required date of submission (i.e., 180 days after the date of SERVICE or discharge plus one year), if it was not reasonably possible for the claim to be submitted within 180 days, and if the claim was submitted as soon as possible thereafter. Force majeure is assumed to be the standard for a provider's reasonable inability to file a claim within the established time frame, though contracts may include provisions establishing more generous standards. When the claimant is the insured, legal incapacity could extend the filing time beyond the one year extension. [Refer to G.S. 58-3-225(f)]

Regarding:

38. When must insurers that qualify for delayed compliance with the law be in full compliance? Insurers that qualify for delayed compliance will be subject to the law when their new claims processing systems are implemented, beginning as claims are entered into the new system. However, whether or not the new system is fully implemented, the company must be in full compliance for all claims received on or after January 1, 2003.

Following is an update on the insurers that have asserted eligibility for delayed compliance:

Connecticut General Life Insurance Company (CGLIC) CGLIC, a CIGNA affiliate, has advised the Department that all of its claims systems will be capable of complying with the Prompt Pay law effective July 1, 2001. Therefore, this company will be subject to the law when it first goes into effect.

Blue Cross & Blue Shield North Carolina (BCBSNC) All of BCBSNC products, both group and individual, are currently adjudicated using the "legacy" system, except for BCBSNC's newest group products: Blue Options (PPO), Blue Choice (POS), Classic Blue (CMM), and Blue Care (HMO). BCBSNC's "legacy" system, also known as LRHP, was implemented prior to 1982. Group business is being converted to the new products supported by a new claims system as each group renews. Given existing renewal dates, all groups would be converted to a new product and would be in compliance with the prompt pay law, by July 2002. It is possible that some groups will remain on the LRHP system, and changes will be made to bring that system into compliance with the law not later than December 31, 2002. Individual business will be brought into compliance by December 31, 2001, either by moving that business to the new claims system or by modifying the LRHP system. As of December 31, 2000, 524,075 (96%) of total insured lives were covered under a product supported by the legacy system. Of the 524,075 lives, 345,767 are covered under group and 169,308 are covered under individual policies.

WellPath Select, Inc. All of WellPath Select's policies (110,760 as of February 2001) are supported by the GEMS system, which came into use at WellPath via a chain of mergers and acquisitions. The company is working to transfer this business to another system by January, 2002.

SECTION III. ADDITIONAL QUESTIONS AS OF APRIL 27, 2001

- 1. Does the Prompt Pay law apply to claims from out of state providers?** The law applies to the claims payment practices of North Carolina-licensed insurers, without regard to the residence of the provider filing the claim. A claim filed on behalf of a person insured by a North Carolina insurer must be processed in accordance with North Carolina law.
- 2. If a claim status report is not required to be sent on day 60 because the insurer was awaiting information requested from the provider, how soon must the claim status report be sent to the insured once the information is received?** Under 58-3-225(g), a status report is to be provided to the insured in the following circumstance: (1) A claim is unpaid after 60 days, and (2) the insurer is no longer awaiting requested information. Subsequent status reports are then to follow every 30 days thereafter.

Since the law does not specify a time frame for sending the status report after requested information has been received (#2, above), the Department believes it is necessary, for administrative and regulatory purposes, to establish a reasonable compliance standard. The Department will consider companies to be in compliance with this provision if the claim status report is mailed to the insured within 5 business days of receipt of the additional information. If the claim is paid or denied within the 5 business days of receipt of the additional information, then no claim status report is required.

- 3. How does the 180-day limit for claims filing apply when the insurer is a secondary payor?** The prompt pay law requires that insurers allow at least 180 days from the date of service or discharge for a claim to be filed, but they may allow more time than that. No distinction is made in the law for primary or secondary coverage. The processing requirements and time frames would apply beginning with the date the claim is filed, whether the claim is for primary or secondary coverage.

Nothing prohibits an insurer from establishing a COB policy that allows a longer filing period when the insurer is secondary. For example, an insurer may require a provider to file a claim within a specified number of days after payment is received from the primary insurer. Indication of a fair business practice would be equitable treatment of all COB claims, in accordance with state law and the insurer's own established policies.

- 4. If a claim is denied due to missing information, may the claimant later re-submit the claim including the information that was missing when the first claim was filed? If so, what time limit applies for re-submitting the claim?** Insurers should be sure that a denial due to missing information is done in good faith. The denial notice issued must include all of the reasons for denial, including the fact that information is missing and what that information is. A claimant may choose to resubmit the claim including the information that had previously been identified as missing. This resubmission would be treated as a new claim filing subject to the Prompt Pay law and the insurer's policy or provider contract terms for submitting claims. By law, the policy and contract must allow at least 180 days from the date of service or, for inpatient services, date of discharge. An insurer cannot deny a claimant the right to re-file a claim that was denied due to missing information, when the claimant is able to provide the missing information with the resubmission. An insurer may establish, communicate, and enforce procedures that require resubmissions to indicate that additional or corrected information is included with the resubmission so as to enable the insurer to distinguish resubmissions from duplicate filings.
- 5. How does the prompt pay law impact interim billing by a provider? Can the claim be pended as an "incomplete claim" or "unclean claim"?** An insurer must pay any portion of a claim for which proof of loss can reasonably be established. If no part of the claim is payable, then the insurer can either deny the claim, itemizing all of the "good faith" reasons for the denial, or it can pend the claim and itemize all of the missing information required. Either way, the claim must be handled in accordance with applicable time standards.
- 6. If a claim cannot be processed because of missing information, can the insurer deny the claim and request information, instead of pending the claim? If the insurer denies the claim, must they deny it again after 90 days if the missing information is not submitted?** See answer in number 4 and 5, above. The insurer must either pay, deny or pend a claim or portion of a claim. If information is missing, the insurer can either deny or pend the claim. If the claim is denied, they must provide all of the reasons for the denial. Even if some of the reasons for denial relate to missing information, the claim is still denied and not pended.
- 7. When a claim that is submitted by a provider is denied, must the insurer send a denial notice to the insured?** In cases where the provider is not permitted to bill the patient in the event of claim denial, no notice must be given to the insured. If the insured remains liable for payment to the provider in the event of claim denial, the notice of denied claim must go to the insured as well as the provider, since they would both qualify as claimants.
- 8. If an insurer receives a claim and requests information, then receives another claim for which they need the same information that has already been requested, do they have to request the information again?**

Every claim must be handled in accordance with the law. The insurer may either deny the second claim, itemizing all of the good faith reasons for the denial, or pend it and specify the missing information. An earlier request for the same information relating to another claim does not remove the requirement to process later claims in accordance with the law. However, once the information is received in response to either request, processing should continue for both claims.

- 9. There should be guidelines for sufficient evidence to rebut the presumed date of receipt of payment, similar to the evidence for rebuttal of the presumed date of receipt of a claim, as outlined in the Department's guidance issued February 21, 2001(Question #3).** The law establishes a presumed date that payment is made [G.S. 58-3-225(e)], but not a presumed date payment is received. The Department will apply a standard of proof similar to that outlined in the above-referenced guideline, to assertions by providers that payment was not made on the presumed date.
- 10. Are dental plans subject to Prompt Pay?** Yes. The definition of "health benefit plan" in 58-3-225 does not specifically exclude dental plans, so they are included among insurers subject to the law.
- 11. In a case where the insured fails to provide COB information to the insurer or provider when asked for that information, and the insurer denies a claim submitted by a provider because COB information is missing, may the provider ever balance-bill the insured?** In a case where a claim denial is solely the result of a member's failure to provide COB information, any member hold-harmless provision or restriction on balance billing would not apply since the member would not have fulfilled their obligations with respect to the health benefit policy or assignment of benefits.
- 12. The insurers who have so far qualified for a delayed effective date for compliance have some of their membership on a "new" claims system that is subject to the law on July 1, 2001, and some on an "old" system that qualifies for the extension. How can providers confirm when a claim submitted to one of these insurers is on the "old" system?** The Department will post quarterly information about the number of insureds and, if applicable, the product names supported by these companies' "old" claim system. The information will be posted on the Department's web site, www.NCDOI.com, under the section with information for providers. However, this information will be of limited usefulness. Providers will need to rely on insurers to provide information relative to a specific patient and whether a claim for services provided to them is subject to the Prompt Pay law.