OKLAHOMA INSURANCE DEPARTMENT

A PROVIDER'S GUIDE TO DEALING WITH

DELAYED CLAIMS

HOW TO AVOID FILING ERRORS

- Know your contractual obligations, including where to file claims, claim filing deadlines, and your fee schedule.
- File claims to the correct address; file claims with carriers in a timely manner.
- File claims using a method that documents when the claim was received by the carrier.
- Keep records of your phone conversations and all written correspondence with each carrier regarding status of a claim.
- Update your accounts receivable as soon as claim payments are received.

ASSISTANCE FOR PROVIDERS

Be sure to include the following when filing a complaint with the Oklahoma Insurance Department regarding a delay in claim payment:

1. A copy of the patient's health insurance ID card
2. A copy of the claim form submitted to the company for each patient and date of service

- Evidence of claim submission in the form of:

1. Electronic filing
2. Certified mail receipt, or
3. Courier delivery confirmation

- Evidence of your collection activities for each claim prior to contacting the Oklahoma Insurance Department. That evidence should be in the form of:
  1. Documentation of phone conversations made to health carrier
  2. Copies of correspondence mailed to the health carrier
  3. Replies you have received from the health carrier
- Be sure to separate claims by the insurance carrier name. Claims for one insurance carrier must be grouped together and alphabetized by the patient's last name. If there is more than one claim form for the same patient, please staple the forms together.
- Accurate claim submission can prevent most claim problems. Make sure your claim forms are filled out completely and accurately and that you use the insurance company's correct mailing address. If possible, submit your claim forms electronically.
- Electronic clearinghouses reject claims submitted with incomplete, invalid, or incorrect member identification numbers. If an insurance company returns a claim because of mistakes, correct them immediately and resubmit the claim to meet the filing deadline specified in your contract.

Regulatory AUTHORITY

The Oklahoma Insurance Department regulates insurance companies that are fully insured, Health Maintenance Organizations (HMOs), third party administrators (TPAs), and idemnity plans. Some issues may fall under another agency's jurisdiction, and OID may not be able to help you.

The Oklahoma Insurance Department has no regulatory authority over complaints regarding:

- Self-insured/Self-funded employee organization plans under the Federal Employee Retirement Income Security Act (ERISA)
- Workers' compensation (unless presented with a court order)
- Government, school, and church health plans
- Out-of-state insureds
- Medicare/Medicaid
- State Employees
- Teachers Retirement System
- TRICARE/Champus
- Bundling and unbundling claims
- Usual and customary charges
- Provider contract disputes
- Medical necessity issues

The Oklahoma Insurance Department receives hundreds of complaints each month.

A complaint is justified if there is a violation of state law, rules, or policy provisions.Individual employers and certain employee organizations may self-fund their employee health benefit plans under the authority of ERISA. State law, including Title 36 section 1219, the Clean Claims Law, does not apply to self-funded plans. The U.S. Department of Labor oversees the self-funded plans.

If an Oklahoma-licensed TPA processes claims for a self-funded plan, our office will contact the TPA on your behalf, although our authority is limited. We suggest that you encourage your patients to follow the complaints and appeals process outlined in their benefits booklets. (These plans may have deadlines for filing complaints and appeals that the patient must meet.)

QUESTIONS & ANSWERS

Q. An insurance company paid my patient instead of me. Now I can't collect from either one. Can OID help?

A. OID may be able to assist depending on the patient's plan. File a request for assistance and explain the circumstances involved. Include a copy of the signed assignment of benefits.

Q. Why was the claim denied after the company pre-authorized the procedure?

A. Pre-authorization is not a guarantee of payment. It only means the treatment is considered medically necessary. A company determines if a claim is payable after receiving the claim with documentation and reviewing it against the patient's benefit plan policy.

Q. I believe the insurance company/PPO unfairly reduced my billed amount. What can I do?

A. Work with your health care plan providers' relations contact to resolve your problem. Contracting parties must resolve disputes about contract terms among themselves. *You should always review and understand your contract before you sign it.*

CLEAN CLAIMS LAW

Title 36 SECTION 1219 of the Oklahoma Statutes (Revised April 2007)

A. In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of the claim by the insurer.

B. As used in this section:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state, and any subscriber certificate or any evidence of coverage issued by a health maintenance organization to any person in this state;

2. "Clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and

3. "Insurer" means any entity that provides an accident and health insurance policy in this state, including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a health maintenance organization, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.

C. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy. Provided, if a claim is not submitted into the system due to a failure to meet basic Electronic Data Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA) edits, electronic notification of the

CLEAN CLAIMS LAW

Title 36 SECTION 1219 of the Oklahoma Statutes (Revised April 2007)

Continued

failure to the submitter shall be deemed compliance with this subsection. Provided further, health maintenance organizations shall not be required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee or subscriber of any claim defect or impropriety.

D. Upon receipt of the additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, an insurer shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney fee to be set by the court and taxed as costs against the party or parties who do not prevail.

H. The Insurance Commissioner shall develop a standardized prompt pay form for use by providers in reporting violations of prompt pay requirements. The form shall include a requirement that documentation of the reason for the delay in payment or documentation of proof of payment must be provided within ten (10) days of the filing of the form. The Commissioner shall provide the form to health maintenance organizations and providers.

I. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.

www.oid.ok.gov | 1.800.522.0071
400 NE 50th Street, Oklahoma City, OK. 73105