3901-1-60 **Unfair health claim practices.**

(A) Authority

Section 3901.041 of the Revised Code provides that the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications, necessary to discharge his duties and exercise his powers under Title XXXIX of the Revised Code.

Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section.

Section 3901.3813 permits the superintendent to adopt rules as the superintendent considers necessary to carry out the purposes of section 3901.38 and sections 3901.381 [3901.38.1] to 3901.3812 [3901.38.12] of the Revised Code.

(B) Purpose

The purpose of this rule is to define certain additional unfair trade practices and to set forth minimum standards in connection with the investigation and disposition of health claims arising under policies, certificates or contracts issued pursuant to Ohio's insurance statutes, rules and regulations under Titles XVII and XXXIX of the Revised Code. It is not to cover claims involving Medicare, Parts A or B; Medicaid, the Tricare Program or workers' compensation insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this rule.

(C) Definitions

~~All definitions contained in section 3901.19 of the Revised Code and rule 3901-1-07 of the Administrative Code are hereby incorporated by reference. As otherwise used in this rule:~~

~~(1) "Agent" means any individual, corporation, association, partnership or other legal entity licensed pursuant to Titles XVII or XXXIX and authorized to represent a third-party payer or insurer with respect to a claim.~~

~~(2) "Beneficiary" means the party entitled to receive the proceeds or benefits under the policy.~~

~~(3) "Benefit Plan" means the coverage as described in the insurance policies, certificates, summary plan descriptions or other documents which are~~

~~prepared by the third-party payer or under the direction and control of the third-party payor describing the scope of benefits provided to a beneficiary by a third-party payer.~~

~~(4)~~(1) "Claim" means any~~the~~ request submitted to a third-party payer for benefits or proceeds under a benefit plan or contract on a standardized health claim form as described in Ohio Administrative Code Section 3901-1-59.

~~(5) "Claimant" means the insured, provider, beneficiary or legal representative of the insured, including a member of the insured's family designated by the insured, making a claim under a benefit plan.~~

~~(6) "Claim File" means a collection of information or data required for the payment or denial of a claim, regardless of the medium.~~

~~(7) "Completed Claim" means a payment request submitted to a third-party payer which is accompanied by reasonable and sufficient information that will enable the third-party payer to accept or reject the claim.~~

~~(8)~~(2) "Coordinated Care" means the management of health care services by a third-party payer for a ~~claimant~~beneficiary. Examples include, but are not limited to, provider selection or referral, preadmission certification, length of stay determination and second surgical opinions.

~~(9)~~(3) "Day" means calendar day. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday or state or federal holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday or holiday.

~~(10)~~(4) "Deny or Denial" means a refusal to pay any portion of a claim. The application of contractual co-pays and deductibles are not considered a denial of a claim.

~~(11)~~(5) "Documentation" includes, but is not limited to, all supporting documentation as defined in 3901.381(B)(2) and any records of~~pertinent~~ communications~~,~~ or activities~~transactions~~, notes, work papers, claim forms, bills and explanation of benefit forms relative to a claim, including the electronic transmission of the data contained in such items.

~~(12) "Insured" means a person enrolled under a benefit plan or the dependent of a person enrolled under a benefit plan.~~

~~(13) "Investigation" means activities of any third-party payer directly or indirectly related to the determination of liabilities under coverages afforded or~~

allegedly afforded by the third-party payer.

(14) "Notification of Claim" means any notification, whether in writing or other means acceptable under the terms of a benefit plan to a third-party payer or its agent, by or on behalf of a claimant, which reasonably apprises the third-party payer of the facts pertinent to a claim.

(15) "Person" shall be defined as set forth in section 3901.19 of the Revised Code.

(16) "Practice" means a type of activity or conduct engaged in by an insurer with such frequency as to constitute a customary procedure or policy routinely followed in the settlement of claims. A single act is not a business practice. However, an act that is malicious, deliberate, or knowing may be the basis for corrective action ordered by the superintendent without a showing that the conduct is a practice.

(17) "Proof of Loss" means evidence such as claim forms, medical bills, medical authorizations or other reasonable documentation of the claim that is ordinarily required of all claimants.

(18) "Provider" means any person furnishing health care services or supplies.

(19) "Reasonable Explanation" means information sufficient to enable the claimant to determine whether all appropriate benefits of the benefit plan have been made.

(20) "Superintendent" means the superintendent of the Ohio department of insurance.

(21) "Third party payer" means any of the following:

(a) An insurance company;

(b) A health maintenance organization;

(c) A preferred provider organization;

(d) A labor organization;

(e) An employer;

(f) A prepaid dental plan organization;

(g) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;

(h) A multiple employer welfare arrangement subject to sections 1739.01 to

~~1739.99 of the Revised Code;~~

~~(i) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.~~

~~(22) "Written Communication" includes all correspondence, regardless of source, type or medium, that is materially related to the handling of a claim.~~

(D) General claim practices

(1) A third-party payer shall notify the beneficiary and the provider of the denial of any claim. The notification shall include the specific reasons for the denial and the contract provision, condition, limitation or exclusion of the benefit plan or contract that is the basis for the denial of payment for the claim. The information must be provided in such a way that a reasonable person would understand the reasons and basis for the denial.

~~(1) A third-party payer shall, within fifteen days of receipt of notification of a claim, provide necessary claim forms and instructions and assist the claimant in complying with its claim filing requirements.~~

~~(2) A third-party payer shall acknowledge or respond within twenty-four days of receipt of any written communication from a claimant other than the initial claim filing.~~

~~(3) A third-party payer shall notify the claimant of denial of a claim when it has no liability and identify the benefit plan provision, condition, or exclusion upon which the denial is based.~~

~~(4) No third-party payer shall deny a claim based on information obtained in a conversation with any source, unless both the information and the source are documented in the claim file.~~

~~(5)~~(2) No third-party payer shall indicate to a ~~claimant~~beneficiary or provider on an electronic payment or transmittal, payment draft, check, or in any ~~accompanying letter~~communication that the payment is "final" or a "release of claim" unless the third-party payer has paid the benefit plan~~'s~~ or contract's limit or the ~~claimant~~ provider or beneficiary has agreed to a compromise settlement.

~~(6)~~(3) When a third-party payer administers more than one benefit plan under which a beneficiary may make a claim for benefits and has been notified by the beneficiary or provider that more than one claim may be filed for benefits, the third-party payer shall establish procedures to eliminate duplicate

processing procedures and to encourage concurrent processing of the claims.

~~(7)~~(4) The third-party payer shall inform the ~~claimant~~ beneficiary or provider with specificity what supporting documentation ~~when additional information~~ is required to determine whether additional benefits would be payable.

~~(8) No third-party payer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim unless:~~

~~(a) The claimant has no reasonable basis to dispute the prior overpayment; and~~

~~(b) The overpayment was clearly erroneous under the provisions of the benefit plan or provider contract or other applicable agreement; and~~

~~(c) The third-party payer has notified the claimant(s) of the error within the later of six months of the date of payment for benefits issued or fifteen days of discovery of an error prompted by misrepresentations or non-disclosures of claimants or third parties; and~~

~~(d) The third-party payer notified the claimant(s) of the amount and basis for the adjustment at the time it was made; and~~

~~(e) Notwithstanding the above, a provider and a third-party payer may enter into a contractual agreement regarding adjustments or corrections for overpayments so long as any non-provider claimant is held harmless, where it is clear the non-provider claimant did not not contribute to the overpayment; and~~

~~(f) This division shall not prevent a third-party from recovering overpayments through normal legal channels.~~

~~(E) Timely payment of health claims~~

~~(1) Within twenty-one days of receiving a proof of loss, the third-party payer must request any information needed to complete a claim.~~

~~(2) Within twenty-four days of receiving a completed claim, a third-party payer shall either deny the claim or tender payment of any amount not in dispute, except that a third-party payer and a provider may, in negotiating a reimbursement contract, agree to any time period by which a third party shall make payment of any amount due on a completed claim.~~

~~(3) The third-party payer shall provide the claimant with a reasonable explanation of benefits.~~

~~(F)~~(E) Coordinated care practices

(1) Every third-party payer with coordinated care provisions in a benefit plan or contract shall:

(a) Fully explain in the policy and certificate the procedures required for compliance with coordinated care provisions, including all penalties for failure to comply with those procedures.

(b) Process claims for any services or procedures which the third-party payer has authorized pursuant to the ~~claimant's~~ beneficiary's or provider's compliance with coordinated care procedures subject to non-coordinated care provisions.

(c) Provide the ~~claimant~~ beneficiary or provider with timely written notification of the confirmation or denial of coverage pursuant to coordinated care requirements of the ~~claimant's~~ beneficiary's benefit plan or contract. Unless the third-party payer has determined that all claims will be paid in full or denied, the notification shall include the following statement at the top of the notice, in twelve point bold face type, before any other textual information:

This is not an approval for claim payment

Confirmation of (particular coordinated care provision) only

We have not yet reviewed the patient's health care plan. Depending on the limitations of the health care plan, we may pay all, part, or none of the claims.

~~(G)~~(F) Reporting insurance fraud

If a third-party payer reasonably believes, based upon information obtained and documented, that a ~~claimant~~ beneficiary or provider has fraudulently caused or contributed to the claim as represented by a properly executed and documented claim form or billing, such information shall be presented to the fraud division of the Ohio department of insurance within sixty days of when the fraud becomes evident. Any person making such report shall be afforded such immunity and the information submitted shall be confidential as provided by sections 3901.44 and 3999.31 of the Revised Code.

~~(H)~~(G) File and record documentation

~~Each third-party payer's claim files shall be subject to examination by the superintendent of insurance or by his/her duly appointed designees. To aid in such examination:~~

Each third-party payer shall maintain complete documentation of every claim for a period of three years. The documentation shall be sufficient to permit complete reconstruction of the third-party payer's activities and communications with respect to each claim. Documentation shall include the date of each activity or communication. All documentation shall be reproducible to paper.

~~(1) Every third-party payer shall maintain complete claims data that are accessible and retrievable for examination. All data used to process the claim shall be available for both open and closed files for no less than three years, or until the completion of the next financial examination conducted by the state of domicile, whichever is greater.~~

~~(2) Each claim file shall contain detailed documentation sufficient to permit reconstruction of the third-party payer's activities relative to each claim.~~

~~(3) Third-party payers who do not maintain paper files must have claim files accessible and reproducible to paper.~~

~~(I)~~(H) Complaint procedure

Every third-party payer shall:

(1) Establish and maintain a procedure for the expeditious resolution of both written and oral complaints initiated by ~~insureds~~ beneficiaries and providers.

(2) Include the third party ~~payor's~~ payer's complaint procedure in every benefit plan, contract or certificate. ~~For purpose of implementing this requirement, the disclosure of the complaint procedure shall be given with every new benefit plan or certificate issued pursuant to a benefit plan that is issued ninety days after the effective date of this rule. With respect to benefit plans or certificates, this requirement begins with the first renewal of the benefit plan that occurs ninety days after effective date of this rule.~~

(3) ~~Records~~ Keep records of written complaints from and responses to beneficiaries and providers ~~shall be available to the superintendent for inspection~~ for three years.

(4) Include the following statement or a substantially similar statement on all notification of claim denials:

"If you wish to dispute the company's decision on this claim, you may register a complaint by (insert third-party ~~payor's~~ payer's procedure): (insert address of office). In reviewing your complaint, the company will follow the complaint procedure described in your benefits plan."

(5) Include the following statement on the written notice to a~~n insured~~ beneficiary of the company's final adjudication of a complaint:

"If you disagree with the company's decision, you have the right to file a complaint with the Ohio Department of Insurance, Consumer Services Division, 2100 Stella Court, Columbus, Ohio ~~43266-0566~~43215-1067, (614)-644-2673, toll free in Ohio 1-800-686-1526."

~~(J) Unfair and deceptive practice~~

~~Failure to comply with any requirements of sections (D) to (J) of this rule is an unfair and deceptive practice within the meaning of section 3901.21 of the Revised Code. Health maintenance organizations licensed pursuant to Chapter 1742 of the Revised Code are subject to both sections 1742.16 and 3901.21 of the Revised Code.~~

~~(K)~~(I) Penalties

The Superintendent may impose sanctions according to Revised Code Section 3901.3812 for violations of paragraphs (D)(1) or (D)(4) of this rule. All other violations of this rule are unfair and deceptive practices within the meaning of Revised Code Section 3901.21 and are subject to ~~The superintendent may impose~~ the penalties set forth in section 3901.22 of the Revised Code. Any agreement consented to pursuant to division (G) of section 3901.22 of the Revised Code may include the recovery of the costs of the investigation in addition to the penalty so agreed.

~~(L)~~(J) Effective date

This rule will take effect on ~~October 1, 1994~~_____.

~~(M)~~(K) Severability

If any section, term or provision of this rule be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this rule, but the remaining sections, terms, and provisions shall be and continue in full force and effect.

Effective: 10/28/2002

R.C. 119.032 review dates: 07/18/2002 and 12/31/2006

CERTIFIED ELECTRONICALLY

Certification

10/18/2002

Date

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