



Office of Health Insurance Commissioner  
1511 Pontiac Avenue  
Cranston, Rhode Island 02920

# Health Insurance Commissioner Bulletin Number 2018-4

## Forms for compliance with Prompt Processing of Claims

The following forms are designated for use in compliance with 230-RICR-20-30-6 – Prompt Processing of Claims.

- Exhibit A - Measurement of Substantial Compliance
- Exhibit B - Prompt Processing Report and Instructions
- Exhibit C – Prompt Processing Complaint Form

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

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

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

- Pay interest on claims not paid within the required timeframes,
- File claims processing reports with the Office of the Health Insurance Commissioner, and
- Provide complete claim standards to participating providers.

**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
<b>A. Paid Paper Claims</b>					
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>B. Paid Electronic Claims</b>					
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)				
<b>C. Processed Claims that are Denied or Pended</b>					
1	Number of Claims Denied or Pended During Time Period				
2	Number of Claims Denied or Pended Within 30 Days				
3	% of Claims Denied or Pended Within 30 Days (C.2/C.1)				
<b>D. Percent of Claims Paid, Denied or Pended Within Statutory Timeframes</b>					
1	Number of Complete Paper Claims Paid Within 40 Days				
2	Number of Complete Electronic Claims Paid Within 30 Days				
3	Number of Claims Denied or Pended 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 Denied or Pended During Time Period				
7	Percent of Claims Paid and Processed Within Statutory Timeframes				
<b>E. Overall Compliance for Review Period</b>					

I \_\_\_\_\_ the \_\_\_\_\_ of \_\_\_\_\_ 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**  
**Prompt Processing Report**  
**Reporting Period (Month/Year or Year)\_\_\_\_\_**

**Insurer/Plan Name**\_\_\_\_\_

**Contact Person/Address**\_\_\_\_\_

**Telephone/Email**\_\_\_\_\_

***Claims Processing Data***  
***(Data for Claims Paid, Pended or Denied)***

	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>	<u>Column D</u>	<u>Column E</u>	<u>Column F</u>
	Total number of claims received	Total number of claims processed	Total number of claims processed within statutory timeframes	Total number of claims processed outside statutory timeframes	Average processing time (in days) for claims processed within statutory timeframes	Average processing time (in days) for claims processed outside statutory timeframes
<b>Fully Insured, Self Insured, and RIte Care Claims</b>						

***Claims Payment Data***  
***(Data for Claims Paid)***

	<u>Column G</u>	<u>Column H</u>	<u>Column I</u>	<u>Column J</u>	<u>Column K</u>	<u>Column L</u>
	Total number of claims paid	Total number of claims paid within statutory timeframes	Total number of claims paid outside statutory timeframes	Average processing time (in days) for claims paid within statutory timeframes	Average processing time (in days) for claims paid outside statutory timeframes	Total interest paid on claims paid outside statutory timeframes
<b>Fully Insured, Self Insured, and RIte Care Claims</b>						



## **Instructions**

Submit pages one and two of this Exhibit according to the requirements of section 7 of this regulation and these instructions. The certification must be signed by an officer, director, or other person with authority to sign on behalf of the subject entity. The Exhibit should be submitted to:

Office of the Health Insurance Commissioner  
Attn.: Provider Liaison  
1511 Pontiac Ave.,  
Building 69-1  
Cranston, RI 02920

The terms on page one has the following meanings:

### Column A

“Total number of claims received” means the total number of claims (as defined by section 3(b) of this regulation) for health care services (as defined by section 3(k) of this regulation) received by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during the reporting period (one month or one year), regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 15,000 claims were received by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, from June 1 to June 30 of 2007,

the number in Column A would be 15,000.

### Column B

“Total number of claims processed” means the total number of claims for health care services processed (as defined by section 3(r) of this regulation) by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 14,500 claims were processed (paid, pended or denied) by the subject entity or other entities acting on behalf of or for the subject entity, from June 1 to June 30 of 2007,

the number in Column B would be 14,500.

### Column C

“Total number of claims processed within statutory timeframes” means the total number of claims for health care services processed within the timeframes established by section 4(a) of this regulation by the subject entity or by any agents, contractors, subsidiaries or

other entities acting on behalf of or for the subject entity, during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 14,500 claims were processed (paid, pending or denied) by the subject entity or other entities acting on behalf of or for the subject entity, from June 1 to June 30 of 2007; and
- 3) 14,410 of the 14,500 claims processed during June of 2007 were paid, pending or denied within the required timeframes,

the number in Column C would be 14,410.

#### Column D

“Total number of claims processed outside statutory timeframes” means the total number of claims for health care services processed outside the timeframes established by section 4(a) of this regulation by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 14,500 claims were processed (paid, pending or denied) by the subject entity or other entities acting on behalf of or for the subject entity, from June 1 to June 30 of 2007, for all plans operated in Rhode Island; and
- 3) 90 of the 14,500 claims processed during June of 2007 were paid, pending or denied outside the required timeframes,

the number in Column D would be 90.

#### Column E

“Average processing time (in days) for claims processed within the statutory timeframes” means the average number of days, rounded to one decimal place (e.g., 4.3), the subject entity, or any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, took to process claims for health care services that were paid, pending or denied within the timeframes established by section 4(a) of this regulation during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period;
- 2) 14,410 of the 14,500 claims processed during June of 2007 were paid, pending or denied within the required timeframes; and
- 3) 12,000 of the 14,410 claims were processed within three days of receipt by the subject entity, 2,000 of the 14,410 claims were processed within four days of receipt by the subject entity and 410 of the 14,410 claims were processed within five days of receipt by the subject entity,

the number in Column E would be 3.2.<sup>2</sup>

#### Column F

“Average processing time (in days) for claims processed outside the statutory timeframes” means the average number of days, rounded to one decimal place (e.g., 4.3), the subject entity, or any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, took to process claims for health care services that were paid, pending or denied outside the timeframes established by section 4(a) of this regulation during the reporting period, regardless of whether such claims are electronic or written. The number reflected in this column should be the average number of days **beyond** the payments timeframes. In other words, the number of days in the payment timeframes (thirty for electronic claims and forty for written claims) should not be included in the figure used in this column. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 90 of the 14,500 claims processed during June of 2007 were paid, pending or denied outside the required timeframes; and
- 3) 20 of the 90 claims were processed four days beyond the timeframes established by this regulation, 25 of the 90 claims were processed five days beyond the timeframes established by this regulation and 45 of the 90 claims were processed six days beyond the timeframes established by this regulation,

the number in Column F would be 5.3.<sup>3</sup>

#### Column G

“Total number of claims paid” means the total number of claims for health care services paid (as defined by section 3(r) of this regulation) by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 14,000 claims were paid by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, from June 1 to June 30 of 2007,

the number in Column G would be 14,000.

#### Column H

“Total number of claims paid within statutory timeframes” means the total number of claims for health care services paid within the timeframes established by section 4(a) of this regulation by the subject entity or by any agents, contractors, subsidiaries or other

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<sup>2</sup> The figure 3.2 is calculated as follows:  $((12,000*3)+(2,000*4)+(410*5))/14,410=3.1957$ , rounded up to 3.2.

<sup>3</sup> The figure 5.3 is calculated as follows:  $((20*4)+(25*5)+(45*6))/90=5.2778$ , rounded up to 5.3.

entities acting on behalf of or for the subject entity, during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 13,970 of the 14,000 claims paid by the subject entity, or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during June of 2007 were paid within statutory timeframes,

the number in Column H would be 13,970.

#### Column I

“Total number of claims paid outside statutory timeframes” means the total number of claims for health care services paid outside the timeframes established by section 4(a) of this regulation by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period; and
- 2) 30 of the 14,000 claims paid by the subject entity, or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity, during June of 2007 were paid outside statutory timeframes,

the number in Column I would be 30.

#### Column J

“Average processing time (in days) for claims paid within the statutory timeframes” means the average number of days, rounded to one decimal place (e.g., 4.3), the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity took to pay all claims for health care services that were paid within the timeframes established by section 4(a) of this regulation during the reporting period, regardless of whether such claims are electronic or written. Thus, if:

- 1) June of 2007 is the reporting period;
- 2) 13,970 claims were paid during June of 2007; and
- 3) 13,900 of the 13,970 claims paid during June of 2007 were paid within the required timeframes; and
- 4) 13,000 of the 13,900 claims were paid within three days of receipt by the subject entity, 800 of the 13,970 claims were paid within four days of receipt by the subject entity and 100 of the 13,970 claims were paid within five days of receipt by the subject entity,

the number in Column J would be 3.1.<sup>4</sup>

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<sup>4</sup> The figure 3.1 is calculated as follows:  $((13,000*3)+(800*4)+(100*5))/13,900=3.0719$ , rounded up to 3.1.

#### Column K

“Average processing time (in days) for claims paid outside statutory timeframes” means the average number of days, rounded to one decimal place (e.g., 4.3), the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject entity took to pay claims for health care services that were paid outside the timeframes established by section 4(a) of this regulation during the reporting period, regardless of whether such claims are electronic or written. The number reflected in this column should be the average number of days *beyond* the payments timeframes. In other words, the number of days in the payment timeframes (thirty for electronic claims and forty for written claims) should not be included in the figure used in this column. Thus, if:

- 1) June of 2007 is the reporting period;
- 2) 13,970 claims were paid during June of 2007; and
- 3) 70 of the 13,970 claims paid during June of 2007 were paid outside the required timeframes; and
- 4) 60 of the 70 claims were paid four days beyond the statutory timeframe and 10 of the 70 claims were paid five days beyond the statutory timeframe,

the number in Column K would be 4.1.<sup>5</sup>

#### Column L

“Total interest paid on claims paid outside statutory timeframes” means the total dollar amount of interest paid by the subject entity or by any agents, contractors, subsidiaries or other entities acting on behalf of or for the subject to providers and policyholders on claims for health care services that were paid outside the timeframes established by section 4(a) of this regulation, during the reporting period, regardless of whether such claims are electronic or written.

#### Fully Insured, Self-Insured and RIte Care Claims

The total number of claims for health care services, regardless of whether the claims are fully insured, self-insured or RIte Care claims, during the reporting period.

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<sup>5</sup> The figure 4.1 is calculated as follows:  $((60*4)+(10*5))/70=4.1429$ , rounded down to 4.1.

**Exhibit C**  
**Prompt Processing Complaint Form**

Before filing a written complaint regarding a violation of the prompt processing regulation, the Office of the Health Insurance Commissioner (OHIC) strongly recommends that the provider make a committed effort to resolve the issue with the subject entity directly.

In the event that a satisfactory resolution is not achieved, a provider must *first* file a written complaint with the subject entity *before* filing a written complaint with the OHIC. To file a complaint with the subject entity: (1) complete this form, (2) attach *copies* of the claims (do not send original documents) in question, (3) include a detailed written description of the complaint on this form and (4) if the complaint involves multiple claims, please use the spreadsheet form found on page three of this Exhibit.

The complaint should be sent to the subject entity by certified or registered mail, with a return receipt requested, or by any other method of delivery that provides a written proof of delivery. If the complaint is not resolved within forty five days of receipt of the complaint by the subject entity, the provider may file with the OHIC: (1) a copy of the complete complaint package sent to the subject entity (including copies of all documentation sent with the complaint), (2) written proof of delivery of the complaint to the subject entity and (3) all written responses from the subject entity.

This complaint form, and the information it contains, may be submitted to the subject entity and this Office under the treatment, payment, and health care operations activities exception to the federal HIPAA Privacy Rule, set out at 45 C.F.R. §§ 164.501 and 164.506, and the exceptions to the Rhode Island Confidentiality of Health Care Communications and Information Act, set out at R.I. Gen. Laws § 5-37.3-4(b).

The copy of the complaint, proof of delivery and any responses by the subject entity should be submitted to the OHIC at the following address:

Office of the Health Insurance Commissioner  
Attn.: Provider Liaison  
1511 Pontiac Ave.,  
Building 69-1  
Cranston, RI 02920



