# ***DRAFT - NOT FOR FILING***

## 3901-8-11 Unfair health claim practices.

(A) 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. ~~Nothing herein shall be construed to~~ Violation of this rule does not create or imply a private cause of action ~~for violation of this rule~~.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 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 of the Revised Code 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 of the Revised Code permits the superintendent to adopt rules as the superintendent considers necessary to carry out the purposes of section 3901.38 and sections 3901.381 to 3901.3812 of the Revised Code.

(C) Definitions

(1) "Claim" means any 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 rule 3901-8-03 of the Administrative Code.

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

(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.

(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.

(5) "Documentation" includes, but is not limited to, all supporting documentation as defined in division (B)(2) of section 3901.381 of the Revised Code and any records of communications or activities, 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.

(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.

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

(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.

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

(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 beneficiary's or provider's compliance with coordinated care procedures subject to non-coordinated care provisions.

(c) Provide the beneficiary or provider with timely written notification of the confirmation or denial of coverage pursuant to coordinated care requirements of the 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 font, before any other textual information:

This is not an approval for claim payment

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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.

(F) Reporting insurance fraud

If a third-party payer reasonably believes, based upon information obtained and documented, that a 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 and enforcement division of the Ohio department of insurance within sixty days of when the fraud becomes evident. Any person making such report ~~shall be~~ is afforded such immunity and the information submitted ~~shall be~~ is confidential as provided by sections 3901.44 and 3999.31 of the Revised Code.

(G) File and record documentation

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.

(H) Complaint procedure

Every third-party payer shall:

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

(2) Include the third party payer's complaint procedure in every benefit plan, contract or certificate.

(3) Keep records of written complaints from and responses to beneficiaries and providers for three years.

(I) Claim denial dispute procedure

Every third-party payer, that does not otherwise meet the definition of "Health Plan Issuer" as set forth in division (P) of section 3922.01 of the Revised Code, shall:

(1) 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 payer's procedure): (insert address of office). In reviewing your complaint, the company will follow the complaint procedure described in your benefits plan."

(2) Include the following statement on the written notice to the beneficiary and the provider of the company's final adjudication of a complaint:

"If your claim has been denied based on a determination involving medical judgment or if the decision was based on any medical information or the service has been denied on the basis that it is experimental or investigational, you may have a right to request an independent review by an outside medical practitioner. Submit your request in writing to (insert address of third-party payer).

If your claim has been denied on the basis that it is not a covered service you have the right to file a complaint with the "Ohio Department of Insurance, Consumer Services Division, 50 West Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, 1-614-644-2673, toll free in Ohio 1-800-686-1526." Complaints may also be filed via the internet at http://insurance.ohio.gov."

(J) Penalties

The superintendent may impose sanctions according to section 3901.3812 of the Revised Code for violations of paragraph (D)(1) or (D)(4) of this rule. All other violations of this rule are unfair and deceptive practices within the meaning of section 3901.21 of the Revised Code and are subject to 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.

(K) Severability

~~If any paragraph, term, or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair, or invalidate any other paragraph, term, or provision of this rule, but the remaining paragraphs, terms, and provisions shall be and continue in full force and effect.~~If any portion of this rule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule or related rules which can be given effect without the invalid portion or application, and to this end the provisions of this rule are severable.