

American Podiatric Medical Association State Reference Manual
Part G—Prompt Payment Laws
July 2007

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PAGE'S OHIO REVISED CODE ANNOTATED
TITLE XXXIX. INSURANCE
CHAPTER 3901. SUPERINTENDENT OF INSURANCE
MISCELLANEOUS PROVISIONS

3901.381 Processing of claims by third-party payers

(A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than forty-five days after receipt of the claim. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification.

Not later than thirty days after receipt of the claim, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the

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provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer.

The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a claim. Except as provided in division (B)(2)(b) of this section, if the third-party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

(c) When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(d) If a third-party payer determines that supporting documentation related to medical information is routinely necessary to process a claim for payment of a particular health care service, the third-party payer shall establish a description of the supporting documentation that is routinely necessary and make the description available to providers in a readily accessible format.

Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-9 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration.

(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of

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the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.

It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. A third-party payer may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.

(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply:

(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.

(2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.

(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

(E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section.

Cite to: Ohio Rev. Code Ann. § 3901.381 (2007).

3901.384 Processing of claims not submitted in timely manner

(A) Subject to division (B) of this section, a third-party payer that requires timely submission of claims for payment for health care services shall process a claim that is not submitted in a timely manner if a claim for the same services was initially submitted to a different third-party payer or state or federal program that offers health care benefits and that payer or program has determined

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that it is not responsible for the cost of the health care services. When a claim is submitted later than one year after the last date of service for which reimbursement is sought under the claim, the third-party payer shall pay or deny the claim not later than ninety days after receipt of the claim or, alternatively, pursuant to the requirements of sections 3901.381 to 3901.388 of the Revised Code. The third-party payer must make an election to process such claims either within the ninety-day period or under section 3901.381 of the Revised Code. If the claim is denied, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(B) The third-party payer may refuse to process a claim submitted by a provider if the provider submits the claim later than forty-five days after receiving notice from the different third-party payer or a state or federal program that that payer or program is not responsible for the cost of the health care services, or if the provider does not submit the notice of denial from the different third-party payer or program with the claim. The failure of a provider to submit a notice of denial in accordance with this division shall not affect the terms of a benefits contract.

(C) For purposes of this section, both of the following apply:

(1) A determination that a third-party payer or state or federal program is not responsible for the cost of health care services includes a determination regarding coordination of benefits, preexisting health conditions, ineligibility for coverage at the time services were provided, subrogation provisions, and similar findings;

(2) State and federal programs that offer health care benefits include Medicare, Medicaid, workers' compensation, the civilian health and medical program of the uniformed services and other elements of the Tricare program offered by the United States department of defense, and similar state or federal programs.

(D) Any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

Cite to: Ohio Rev. Code Ann. § 3901.384 (2007).

BALDWIN'S OHIO ADMINISTRATIVE CODE
3901 INSURANCE DEPARTMENT
CHAPTER 3901-1. GENERAL PROVISIONS

3901-1-07 Unfair trade practices

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(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 39 of the Revised Code.

(B) Purpose

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. The purpose of this rule is to define certain additional unfair trade practices and to set forth required procedures in connection therewith.

(C) Defined unfair practices

It shall be deemed an unfair or deceptive practice to commit or perform with such frequency as to indicate a general business practice any of the following:

- (1) Knowingly mispresenting to claimants pertinent facts or policy provisions relating to coverage at issue;
 - (a) Misrepresenting a pertinent policy provision by making any payment, settlement, or offer of first party benefits, which, without explanation, does not include all amounts which should be included according to the claim filed by the first party claimant and investigated by the insurer;
 - (b) Denying a claim on the grounds of a specific policy provision, condition, or exclusion without reference to such provision, condition, or exclusion;
- (2) Failing to acknowledge pertinent communications with respect to claims arising under insurance policies in writing, or by other means so long as an appropriate notation is made in the claim file of the insurer, within fifteen days of receiving notice of a claim in writing or otherwise;
- (3) Failing to make an appropriate reply within twenty-one days of all other pertinent communications and/or any inquiries of the department of insurance respecting a claim;
- (4) Failing to adopt and implement reasonable procedures to commence an investigation of any claim filed by either a first party or third party claimant, or by such claimant's authorized representative, within twenty-one days of receipt of notice of claim;

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(5) Failing to mail or furnish claimant or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within fifteen days of receiving notice of claim, unless the insurer, based on the information then in its possession does not yet know all such requirements, then such notification shall be sent, within a reasonable time;

(6) Not offering first party or third party claimants, or their authorized representatives who have made claims which are fair and reasonable and in which liability has become reasonably clear, amounts which are fair and reasonable as shown by the insurer's investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions;

(7) Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;

(8) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(9) Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge, or consent of insureds;

(10) Attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to, by written or printed advertising material accompanying or made part of an application;

(11) Attempting to delay the investigation or payment of claims by requiring an insured and his physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(12) Failing to advise the first party claimant or the claimant's authorized representative, in writing or by other means so long as an appropriate notation is made in the claim file of the insurer, of the acceptance or rejection of the claim, within twenty-one days after receipt by the insurer of a properly executed proof of loss;

(a) Failing to notify such claimant or the claimant's authorized representative, within twenty-one days after receipt of such proof of loss, that the insurer needs more time to determine whether the claim should be accepted or rejected;

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(b) Failing to send a letter to such claimant or, the claimant's authorized representative, stating the need for further time to investigate the claim, if such claim remains unsettled ninety days from the date of the initial letter setting forth the need for further time to investigate;

(c) Failing to send to such claimant or authorized representative every ninety days after the first ninety-day claim investigation period, a letter setting forth the reasons additional time is needed for investigation, unless the delay is caused by factors beyond the insurer's control;

(13) Failing to advise such claimant or claimant's authorized representative, of the amount offered, if such claim is accepted in whole or in part;

(14) Refusing payments of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information;

(15) Failing to adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances, received by the insurer from insureds or claimants;

(16) Failing to pay any amount finally agreed upon in settlement of all or part of any claim or authorized repairs to be made upon final agreement not later than five days from the receipt of such agreement by the insurer at the place from which the payment or authorization is to be made or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

(17) For purposes of this rule, the following definitions shall apply;

(a) "Investigation" shall mean all activities of the company related directly or indirectly to the determining of liabilities under the coverages afforded by the policy. This shall include, but not be limited to, a bona fide effort to contact all insureds and claimants within a reasonable period after notification of loss. Evidence of a bona fide effort must be maintained in the file. The investigation shall be deemed concluded upon the company's affirmation or denial of liability.

(b) "Notice of Claim" as applied to an insurer shall include notification given to an agent of an insurer.

(c) "Settlement of claims" shall mean all activities of the company related directly or indirectly to the determination of the extent of damages due under coverages afforded by the policy. This shall include, but not be limited to, the requiring or preparing of repair estimates.

(d) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday or holiday.

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(D) Severability

If any paragraph, term, or provision of this rule be adjudged invalid for any reason, such 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 in and continue in full force and effect.

Cite to: Ohio Admin. Code 3901-1-07 (2007).