COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE

IN REPLY, PLEASE
REFER TO:

March 9, 2004

RULING NO.: N-E-3-51-2004

TO ALL HEALTH MAINTENANCE ORGANIZATIONS AND ALL DISABILITY INSURERS THAT SUSCRIBE HEALTHCARE PLANS IN PUERTO RICO

RE: LAW No. 104 OF JULY 19, 2002 (PROMPT PAYMENT OF CLAIMS)

Dear ladies and gentlemen:

By means of Law No. 104 of July 19, 2002, the Puerto Rico Legislature adopted the "Law for the Prompt Payment of Claims by Healthcare Providers". Said law added a Chapter 30 to the Puerto Rico Insurance Code with the purpose of setting time limits to the insurers and healthcare maintenance organizations for the payment of claims to the healthcare services providers, as well as to establish the procedure to object the claims presented for payment, among others.

Thereafter, the Office of the Commissioner of Insurance (OCI), promulgated Rule LXXIII of the Regulations of the Puerto Rico Insurance Code, with the purpose of complementing Law No. 104. Notwithstanding the above, several components of the insurance industry have raised certain questions regarding the implementation of Law No. 104 and its Rule. With the intention of clarifying said questions, the OCI establishes the directives applicable to the following matters:

1. Application of Law No. 104 of July 19, 2002 and Rule LXXIII to claims adjudicated prior to the law's effective date.

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Law No. 104 applies to all claims processable for payment that, at the moment that the legislation became effective, had been submitted by participating providers and are pending to be processed, as it also covers any claim in controversy at the time said legislation became effective.

Claims in controversy include those claims adjudicated prior to the effective date of Law 104 and that, at the time said law came into effect, were pending review. Likewise, those claims for which, at the time Law 104 came into effect, the participating provider had established or initiated any negotiation, dialogue or dispute between the provider and the Insurer or Health Maintenance Organization, shall also be considered claims in controversy. Thus, it includes claims partially or totally rejected, denied or objected, whether held by the Insurer, the Health Maintenance Organization or the providers, subject to the prior-established provisions.

These claims are also subject to the payment of the corresponding interests, as established in Article 30.070 of the Puerto Rico Insurance Code, that provides that, "any claim processable for payment that is not paid within the term established, will generate interests in favor of the participating provider, applicable to the total unpaid amount of said claim or over that part of said claim that may be processable for payment, until its payment-in-full, at the prevailing interest rate set by the Commissioner of Financial Institutions".

On the other hand, if a difference or dispute exists regarding the amount claimed, said claim must be processed according to what is established in Article 30.050 of the Puerto Rico Insurance Code that deals with "Claims not Processable for Payment". It will not be considered that a claim is in dispute if the amount that is proposed to be adjudicated, or is adjudicated, by the Insurer or Health Maintenance Organization as payment, conforms to what has been agreed to between the parties, regardless of the amount billed by the provider.

2. **Application of Law No. 104 and Rule LXXIII to the Health Plan of the Commonwealth of Puerto Rico.**

Law 104 and Rule LXXIII shall apply to the following claims for services that are covered with funds from the Health Plan of the Commonwealth of Puerto Rico, administered or retained by the Insurer or Health Maintenance Organization:

- Any claim made by a participating provider whose payment is made directly by the Insurer or Health Maintenance Organization against institutional funds or catastrophic funds.

- Any claim made by a participating provider whose payment is made directly by the Insurer or Health Maintenance Organization, against retained medical funds.

Claims that are not within those described above will not be subject to the provisions of Law 104 or Rule LXXIII.

3. **Coordination of Benefits**

In those cases in which coordination of benefits is required, and those in which the Insurer or Health Maintenance Organization cannot evidence the date when the provider received the determination of payment from the primary plan, we establish as a parameter to begin counting the ninety (90) day term, three (3) business days after the date in which payment was issued by the primary plan.

It is important to note that this parameter will be utilized only and exclusively for those cases in which there is no other way to determine the date in which the provider received the determination of payment from the primary plan.

4. Inconsistencies between Appendix I and II of Rule LXXIII of the Regulations of the Puerto Rico Insurance Code

To correct the inconsistencies existing between Appendix I and II of Rule LXXIII of the Regulations of the Puerto Rico Insurance Code, we must clarify that the correct term is six (6) months; therefore Appendix III(A) is modified to that effect.

5. Re-submission of claims

With the purpose of avoiding the strict application of Article 30.050 of the Puerto Rico Code of Insurance from being unreasonable in certain circumstances, since the same orders the Insurer or Health Maintenance Organization to proceed with the payment of a claim once it receives the requested information or documentation from the provider, we determine the following:

- In those cases in which the required information or documentation is received, as it was requested to the provider, within the prescribed terms and the Insurer and Health Maintenance Organization detects that other information not requested previously is necessary, said Insurer or Health Maintenance Organization will be obligated to pay the claim.

- If the Insurer or Health Maintenance Organization was not in a position to detect the need of such information at the moment of the initial objection to the complaint, then the Insurer or Health Maintenance Organization, will again proceed to object and could again request from the health services provider, the information or the necessary documents, within the term of thirty (30) days provided by said Article 30.050 of the Insurance Code of Puerto Rico. The health services provider in turn, will have thirty (30) days to submit the requested documentation. Once the information is received, the Insurer or the Health Maintenance Organization will proceed according to Article 30.050 of the Puerto Rico Insurance Code.

- In those cases where the information or documentation required is received from the provider and the same proves that the service provided was not covered by the health care plan, the Insurer or Health Maintenance Organization may reject the claim.

- In those cases in which the provider partially submits the documents initially requested, the Insurer or Health Maintenance Organization will proceed to object again and request from the provider the missing information or documents within the term of thirty (30) days provided by said Article 30.050 of the Puerto Rico Insurance Code. The provider in turn, will have thirty (30) days to submit the requested documentation. Once the information is received, the Insurer or Health Maintenance Organization will proceed according to what was stated in the previous paragraphs.

6. **Complaints received by the Insurer without identifying the provider or insured**

For those complaints that do not contain the name of the provider or insured, each Insurer or Health Maintenance Organization must establish a process to identify the provider or insured in any other way, be it by an assigned number, address, phone number or any other reasonable method of identification. If the Insurer or Health Maintenance Organization can not reasonably identify the provider or the insured within the forty (40) days term it has to reject the complaint, such complaint will not be under the provisions of Law 104 or Rule LXXIII. The Insurer or Health Maintenance Provider must retain for inspection by the Office of the Commissioner of Insurance reliable evidence of the procedure carried out to positively identify the health service provider or the insured.

7. **Complaints received in electronic format**

For those cases in which the complaints are received in electronic format, the Insurer or Health Maintenance Organization, must establish those procedures believed to be necessary to prevent the rejection of the entire electronic file if one claim or part of a claim within said file is incomplete.

If the Insurer or Health Maintenance Organization, for reason of technological limitations, finds itself forced to return the entirety of the electronic file, the terms set out by Law 140 and Rule LXXIII to process claims, will be interrupted and will continue counting from the date in which the Insurer or Health Maintenance Organization receives the corrected electronic file.

All Health Maintenance Organizations and all disability Insurers that subscribe health care plans In Puerto Rico are hereby required to acknowledge and strictly comply with the above stated.

Cordially,

Dorelisse Juarbe Jiménez
Insurance Commissioner