STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC - 69
June 16, 2008

TO: All Health Insurers and Health Care Centers Authorized To Conduct Business In Connecticut

RE: Legitimate Disputes – Connecticut Unfair Insurance Practices

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The Connecticut Unfair Insurance Practices Act ("CUIPA"), (see Conn. Gen. Stat. §38a-815 *et seq.*) requires that an insurer or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy pay accident and health claims within 45 days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except:

- Where there is a deficiency in the information needed for processing a claim as determined in accordance with section 38a-477[1], or
- Unless the Insurance Commissioner ("Commissioner") determines that a legitimate dispute exists as to coverage, liability, or damages or that the claimant has fraudulently caused or contributed to the loss[2].

Conn. Gen. Stat. §38a-477 defines what information is necessary for filing a health claim that is not considered deficient. Health insurers and other claim paying entities are

[1] See Conn. Gen. Stat. §38a-816(15) (B). Each insurer, or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than forty-five days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (i) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (ii) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested.

[2] See Conn. Gen. Stat.§38a-816(15) (A). Failure by an insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, to pay accident and health claims, including, but not limited to, claims for payment or reimbursement to health care providers, within the time periods set forth in subparagraph (B) of this subdivision, unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss. Any insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, who fails to pay such a claim or request within the time periods set forth in subparagraph (B) of this subdivision shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen per cent per annum, in addition to any other penalties which may be imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due a claimant or health care provider pursuant to this section is less than one dollar, the insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Care Center.

reminded that if claims are submitted with the necessary information pursuant to Conn. Gen. Stat. §38a-477, the claim is considered under Connecticut law to be a clean claim ripe for processing unless the Insurance Commissioner has determined that a legitimate dispute, pursuant to Conn. Gen. Stat. §38a-816(15)(A) exists. This bulletin is intended to provide guidance as to what the Commissioner considers to be legitimate disputes for which an insurer or other claim paying entity may delay payment while trying to resolve the dispute.

Acceptable Legitimate Disputes Warranting Investigation

The following are considered to be legitimate disputes and appropriate investigational parameters for which an insurer or other claim paying entity may delay payment for a reasonable period while trying to resolve the dispute:

1. **Medical Information necessary to determine if the claim is preexisting.**
   Any investigation undertaken to determine if a claim is preexisting should be consistent with the terms of Insurance Department Bulletin HC-66, dated September 24, 2007. Investigations should be limited to issues having a direct relationship to the alleged pre-existing claim or condition which is the subject of the claim. Any investigation done that is not consistent with the terms of HC-66 may be considered to be post claim underwriting.

2. **Medical information necessary to determine if the services rendered are medically necessary (cosmetic, experimental, etc.).**
   An investigation to determine if the services rendered are medically necessary in conformity with the definition of “medically necessary” pursuant to Conn. Gen. Sta. §38a-482a and §38a-513c.

3. **Medical information necessary to determine if the services are consistent with emergency treatment.**
   Pursuant to Conn. Gen. Stat. §38a-478r, an emergency medical condition is a condition such that a prudent layperson, acting reasonably, would have believed that emergency medical treatment is needed. Each provider is required to code for the presenting symptoms of all emergency claims and each hospital shall record such code for such claims on locator 76 on the UB92 form or its successor. The presenting symptoms, as coded by the provider and recorded by the hospital on the UB92 form or its successor, or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for reimbursement or coverage, provided such symptoms reasonably indicated an emergency medical condition.

   Insurers or health care centers may only investigate if the UB92 claim form is not completed as required above. If the information is presented on the claim form as identified above, this would be considered a claim that is complete pursuant to

Conn. Gen. Stat. §§38a-477 and 38a-815(16)(B) and must be processed without further investigation.

4. **Coordination of benefits payment order or payment information.**
   Coordination of benefit ("COB") information should be investigated upon presentment of the initial claim for payment where there is an indication of dual coverage. COB should not be investigated for subsequent claims more frequently than once yearly unless there is an indication of changed circumstances. COB investigations are acceptable under the following conditions:
   a. to determine payment priority if dual coverage is indicated, or,
   b. if another insurer has been determined to be the primary payor, the secondary carrier may withhold payment until obtaining notification of the primary payment needed to determine secondary liability. The secondary carrier is, however, required to notify the claimant that payment will be withheld until proof of the primary payor's determination has been submitted.

   All COB determinations should be consistent with the Sections 38a-430-1 through 38a-430-7 of the Regulations of the Connecticut State Agencies.

5. **Dependent Eligibility issues.**
   These refer to verification of dependent status for other than routine information which should be contained through enrollment information. Eligibility investigations are acceptable under the following conditions:
   a. to verify whether a dependent child continues to meet the definition of a dependent pursuant to Conn. Gen. Stat. §§38a-497 and 38a-554 as amended by Public Act No. 08-147
   b. if there is indication of a variance from information on file, information may be sought to verify marital status
   c. for mentally or physically handicapped dependents – pursuant to Conn. Gen. Stat. §§38a-489 and 38a-515, proof of the incapacity and dependency shall be furnished to the insurer or health care center by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age; the insurer or health care center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer or health care center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

6. **Accident investigations.**
   Claims for health care services rendered in response to accidental injuries may be investigated if the information regarding the nature of the accident and how the injuries were sustained is not provided, or is not complete. Investigations should be limited to issues having a direct relationship to the accident.

7. **Investigations to rule out suspected fraudulent claims (by member/subscriber or provider).**
   Claim submissions that cause the carrier to suspect alleged fraudulent activity on the part of either the enrollee/member/subscriber or the provider of services may be investigated for cause. Carriers should be prepared to substantiate to the Insurance Commissioner why cause to suspect alleged fraudulent dealings were suspected.

8. **Out of country issues (e.g. monetary conversion rates for the date of service; translation of bills).**
   Claims submitted which contain bills for reimbursement that are in a foreign language or where the charges were made on a non-American currency may be reasonably delayed for purposes of obtaining monetary conversion rates on the date(s) of service or for translation of the bills into English. Unless the circumstances are unusual, these activities should be able to be completed in sufficient time to process the claims in less than 45 days.

In addition, the Department expects health insurers and other claims paying entities to promptly conclude all reviews and investigations described herein. Specifically, when there is a deficiency in the information needed for processing a claim, the Department expects the insurer, health care center or other claim paying entity to send written notice to the claimant and health care provider of the alleged deficiencies and follow up within 30 days where necessary requested information has not been received. Claims should be processed within 30 days of receipt of the necessary information. Health insurers and other claims paying entities taking longer periods of time are potentially subject to review by the Department pursuant to Section 38a-816(6) of the Conn. Gen. Stats. related to unfair claim settlement practices.

The Department believes that most situations necessitating further claim investigation will fall into one of the above categories of legitimate disputes. Therefore, claim settlement delays resulting from investigations or inquiries other than the above conditions will not be considered to be a legitimate dispute pursuant to CUIPA unless the prior approval of the Commissioner is sought and obtained by the claim paying entity for a specific claim pursuant to Conn. Gen. Stat. §38a-816(15)(A). Prior approval can be obtained by identifying the circumstances of the situation and the type of information lacking and necessary to settle the claim; that information, along with a copy of the submitted claim should be submitted to Consumer Affairs for consideration and a recommendation to the Commissioner. The Department will track these requests and add categories to the approved legitimate disputes as they are identified. Any claim settlement delays not considered to be a legitimate dispute, either as provided by the guidelines presented in this Bulletin or through a case by case determination of the Commissioner will be considered a per se violation of CUIPA and subject to the appropriate penalties.

Please contact the Insurance Department Consumer Affairs Division at ctinsdept.consumeraffairs@ct.gov with any questions.

Thomas R. Sullivan
Insurance Commissioner