DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311, 333, 6408 (18 **Del.C.** §§311, 2501, 2304(15)(c) & 2312)
18 **DE Admin. Code** 1313

ORDER

FINAL

1313 Arbitration of Health Insurance Disputes Between Carriers and Providers

Proposed Regulation 1313 relating to the requirements that health insurance carriers submit to arbitration any dispute with a health care provider regarding reimbursement for an individual claim, procedure or service upon request by the health care provider was published in the *Delaware Register of Regulations* on November 1, 2007. The comment period remained open until December 3, 2007. There was no public hearing on proposed Regulation 1313. Public notice of proposed Regulation 1313 in the *Register of Regulations* and two newspapers of general circulation was in conformity with Delaware law.

Summary of the Evidence and Information Submitted

Public comment was received from Coventry Health Care of Delaware, Inc. ("CHCDE"). The comment requested clarification that the phrase "final decision" in the regulation refers to a decision after all internal review processes have been completed. CHCDE also requested that utilization management decisions not be included in the requirement for arbitration, since arbitrators may not have a "strong basis of medical knowledge".

Findings of Fact

Based on Delaware law and the record in this docket, I make the following findings of fact:

1. It is in the public interest to provide a forum in which reimbursement disputes between health care providers and insurance carriers can be resolved in a fair, objective manner without imposing the costs of litigation upon both the health care provider and the insurance carrier; and
2. It is in the public interest that health care providers be given the opportunity to have their reimbursement disputes with health insurance carriers be resolved via arbitration; and
3. It is in the public interest that decisions regarding utilization management be included in the reimbursement disputes that may be submitted for arbitration. Delaware law already requires that when appointing arbitrators, the Insurance Commissioner "endeavor to appoint persons qualified to hear both legal and medical disputes" (18 **Del.C.** §333(e)) and Regulation 1313 requires that arbitrators "be of suitable background and experience to decide the matter." Given that the law and regulations already require that the arbitrators appointed be "qualified" and of "suitable background," there is no reason to exclude certain categories of decisions from being submitted to arbitration. Qualified arbitrators, like judicial officers who hear court proceedings, are able to hear evidence and make a fair and objective decision on the evidence notwithstanding the fact that they may not have a medical background; and
4. The phrase "final decision" refers to a decision made by an insurance carrier after all internal review processes have been completed.

Decision and Effective Date

Based on the provisions of 18 **Del.C.** §§311, 333, and 6408 and the record in this docket, I hereby adopt Regulation 1313 as attached hereto to be effective on February 11, 2008.

IT IS SO ORDERED this 16th day of January, 2008.
Matthew Denn
Insurance Commissioner

1313 Arbitration of Health Insurance Disputes Between Carriers and Providers

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 **Del.C.** §333, which requires health insurance carriers to submit to arbitration any dispute with a health care provider regarding reimbursement for an individual claim, procedure or service upon a request for arbitration by the health care provider. This Regulation is promulgated pursuant to 18 **Del.C.** §§311, 333 and 6408 and 29 **Del.C**., Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Definitions

2.1 "Carrier" or "insurance carrier" shall have the same meaning as defined at 18 **Del.C.** §333(a) (2).

2.2 "Health care provider" or "provider" shall have the same meaning as defined at 18 **Del.C.** §333(a) (1).

3.0 Notice

3.1 At the time a carrier provides to a health care provider written notice of a carrier's final decision regarding reimbursement for an individual claim, procedure or service, if the decision does not authorize reimbursement of the provider's charge in its entirety, the carrier shall give the provider written notice of the provider's right to arbitration. Such notice may be separate from or a part of the written notice of the carrier's decision. Any such notice given to a provider shall, at a minimum, contain the following language:

> "You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322. You may also go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the arbitration process. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

3.2 Such notice is not required if the Commissioner has determined, pursuant to Section 6.0 of this regulation, that the insurance carrier has a program that is substantially similar to the arbitration procedure provided pursuant to 18 **Del.C.** §333 and this Regulation.

4.0 Procedure

4.1 Petition for Arbitration

4.1.1 A health care provider or his authorized representative may request review of a carrier's final reimbursement decision through arbitration by delivering a Petition for Arbitration to the Department so that it is received by the Department no later than 60 days after the date of mailing of the carrier's final reimbursement decision. The Department shall make available, by mail and on its web site, a standardized form for a Petition for Arbitration.

4.1.2 A health care provider or his authorized representative must deliver to the Department an original and three copies of the Petition for Arbitration.

4.1.3 At the time of delivering the Petition for Arbitration to the Department, a health care provider or his authorized representative must also:

4.1.3.1 send a copy of the Petition to the carrier by certified mail, return receipt requested;

4.1.3.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the carrier by certified mail, return receipt requested; and

4.1.3.3 deliver to the Department a non-refundable filing fee. The fee shall be $50 for claims of $1,000 or less, in all other cases the fee shall be $100.

4.1.4 The Department may refuse to accept any Petition that is not timely filed or does not

otherwise meet the criteria for arbitration, including the disputes described in 18 **Del.C.** §333(j)(1) - (3).

4.2 Response to Petition for Arbitration

4.2.1 Within 20 days of receipt of the Petition, the carrier must deliver to the Department an original and three copies of a Response with supporting documents or other evidence attached.

4.2.2 At the time of delivering the Response to the Department, the carrier must also:

4.2.2.1 send a copy of the Response and supporting documentation to the health care provider or his authorized representative by first class U.S. mail, postage prepaid; and

4.2.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the health care provider or his authorized representative.

4.2.3 The Department may return any non-conforming Response to the carrier.

4.2.4 If the carrier fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

4.2.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the carrier.

4.2.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

4.3 Summary Dismissal of Petition by the Department

4.3.1 If the Department determines that the subject of the Petition is not appropriate for arbitration or is meritless on its face, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

4.4 Appointment of Arbitrator

4.4.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

4.4.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the patient whose care is at issue in the dispute.

4.5 Arbitration Hearing

4.5.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

4.5.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

4.5.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

4.5.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

4.5.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed.

4.5.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

4.5.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

4.6 Arbitrator's Written Decision.

4.6.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

4.6.2 The Arbitrator's decision is binding upon the parties except as provided in 18 **Del.C.** §333(f).

5.0 Carrier Recordkeeping Reporting Requirements

5.1 A carrier shall maintain written or electronic records documenting all Petitions for Arbitration including, at a minimum, the following information:

5.1.1 The date the petition was filed;

5.1.2 The name and identifying information of the health care provider on whose behalf the petition was filed;

5.1.3 A general description of the reason for the petition; and

5.1.4 The date and description of the Arbitration decision or other disposition of the petition.

5.2 A carrier shall file with its annual report to the Department the total number of Petitions for Arbitration filed, with a breakdown showing:

5.2.1 The total number of final reimbursement decisions upheld through arbitration; and

5.2.2 The total number of final reimbursement decisions reversed through arbitration.

5.3 A carrier shall make available to the Department upon request any of the information specified in the foregoing sections 4.1 and 4.2.

6.0 Exemption from Arbitration Requirement

6.1 Any carrier having a dispute resolution method established by contract with its providers which method the carrier believes to be substantially similar to the arbitration method described by this regulation may submit information regarding said method to the Insurance Commissioner for a determination as to whether the carrier should be exempted from the arbitration requirement of 18 **Del.C.** §333. The information submitted shall include a copy of the contractual language as well as any other information the carrier believes is relevant to the Insurance Commissioner's decision.

7.0 Non-Retaliation

7.1 A carrier shall not terminate or in any way penalize a provider with whom it has a contractual relationship and who exercises the right to file a Petition for Arbitration solely on the basis of such filing.

8.0 Confidentiality of Health Information

8.1 Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.