Bulletin No. 02-010 **October 7, 2002**

PAYMENT OF HEALTH CLAIMS: PENDED AND DENIED CLAIMS

The Department of Business and Industry, Division of Insurance (Division), has received complaints from consumers and medical providers regarding the late payment of claims by insurers, health maintenance organizations (HMOs), and Third Party Administrators (TPAs). The complaints concern claims that have been delayed as a result of additional information required by the payer.

The Division has worked and continues to work with the industry and medical providers for mutually agreed upon procedures that comply with the laws on the timely payment of claims. In 1998, the Division issued Bulletin 98-003 to address the timely payment of claims and "pended claims." Included in Bulletin 98-003 were several examples of the types of "pended claims" that are illegal. The Bulletin also states that *a claim* may be pended for legitimate additional information as long as the payer furnishes specific reason(s) for the additional information.

Legitimate additional information requested from medical providers must be specific and on an individual claim basis. Requiring additional information as a blanket condition for groups of claims or for claims lacking information without receipting those claims as having been received violates NRS 683A.0879, NRS 689A.410, NRS 689B.255, NRS 689C.485, NRS 695B.2505, and NRS 695C.185.

The Division has also received complaints that insurers, HMOs, and TPAs reject claims based on incorrect coding. The payer returns the claims for adjustments before the claims are logged as having been received in the payer's claims paying system. When the corrected claim is returned, the insurer, HMO, or TPA denies the claim on the basis that the time limit from the date the medical provider rendered the service has been exceeded. This practice is considered "stale dating" and is in violation of NRS 683A.0879, NRS 689A.410, NRS 689B.255, NRS 689C.485, NRS 695B.2505, and NRS 695C.185. The original date the insurer, HMO, or TPA received the claim, whether by written or electronic means, is the date that must be used to determine the timely submission of a claim. Each insurer, HMO, or TPA must have established

procedures to record and prove the date on which the claim was originally received and, whether it was paid, denied, pended, or returned.

Any variations of the foregoing practices in addition to those stated in Bulletin 98-003 that result in delaying tactics will be considered violations subject to disciplinary action, including fines or the suspension or revocation of a certificate of authority, pursuant to NRS 680A.200, NRS 683A.450, NRS 686A.183, NRS 695C.330, or NRS 695C.350 as applicable.

ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

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