

ACT 68 – “Prompt Payment of Clean Claims”

PROCEDURES FOR SUBMISSION OF COMPLAINTS BY MEDICAL PROVIDERS AGAINST HEALTH INSURANCE COMPANIES

1. Before submitting a complaint to our Department, a medical provider must first attempt to resolve the problem with the insurance company and provide our Department with evidence that such attempt at resolution was attempted and failed.
2. To be eligible for submission the claim must meet the following definition of a clean claim: A **Clean Claim**, as defined in Act 68, is “a claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required sustaining documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim.”
3. Provide a cover letter outlining the problem on your office stationary and attach the following documentation to your complaint:
 - (a) Copy of claim form (HCFA-1500 or CMS-1500; UB-92; HCFA-1450) submitted to the insurer.
 - (b) Verify and advise us of the dates the claims were received by the insurance company and that the claim was in fact a clean claim delay **over 45 days** from receipt by the insurance company.
 - (c) Documentation to substantiate your attempts to collect payment from the insurance company, including the names of insurance company employees you talked to including the dates of those discussions.
 - (d) Provide us with all documentation that would substantiate that it is a clean claim delay.

If there are more than ten (10) claims, the claims must be submitted in an excel spreadsheet format. Any complaint submission of more than 10 claims, which is not in the spreadsheet format will be returned to the medical provider. The spreadsheet must include the following claim information:

Name of the insured, Insurance ID Number, Claim Number, Amount Billed, Date of Service, The Date the Claim was Received by the insurance company. (Provide any documentation you have to support the date the insurance company received the claim)

The following situations do not fall under Act 68 prompt payment requirements for review:

1. Claims in which the medical provider is unable to demonstrate what efforts were made to resolve the complaint.
2. Claims that were denied by the carrier, even if you disagree with the reason denied.
3. Claims that are deemed as **unclean** by the insurance company, because of insufficient or incorrect coding provided on the claims submission form.
4. Disagreements in a payment allowances as provided by either the medical provider contract or the insurance policy/plan provisions.

5. Contractual issues regarding the contract between the medical provider and the health insurance company.
6. Access/ Quality of Care or Medical Necessity/Appropriateness issues requiring a medical determination.
7. Health Plans provided under Employee Benefit Trust Funds or Self-Funded Plan.
8. Out-of-State providers not possessing the required Pennsylvania licensure.
9. Complaints regarding health plans that were purchased in a state other than Pennsylvania.
10. Claims that do not meet the definition of a clean claim as defined in Act 68.