ACT 68 – Prompt Payment of Clean Claims

Procedures for submission of complaints by providers against insurers:

1. **When submitting a complaint to the PA Insurance Department a provider must demonstrate and provide evidence of their failed attempt to resolve the matter with the insurer.**

2. To be eligible for submission the claim must meet the following definition of a clean claim:

> ***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 substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim."*

3. Provide a cover letter on your office stationary outlining the problem and attaching the following:

(a) A copy of all insurance cards (front and back) for the patient receiving services for which reimbursement is sought;
(b) Copy of claim form (HCFA-1500 or CMS-1500; UB-92; HCFA-1450) to the insurer;
(c) Verify and advise of the date(s) the claim(s) was received by the insurance company and to substantiate that the claim was in fact a *Clean Claim* **over 45 days;**
(d) Documentation to substantiate attempts to collect payment from the insurer, including by not limited to: claim submission, phone logs, correspondence between you the provider and the insurer, supporting documentation, etc.

If there are more than (10) claims they must be submitted in an Excel spreadsheet. Any such complaint not submitted in this format will be returned.

The spreadsheet must include the following headings: Patient Name; Insurance ID Number with ID card (front and back) attached to the spreadsheet; Claim Number; Date of Service; Charge Amount; Date Claim was Received by the Insurer. (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 allowance 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 otherwise meet the definition of a Clean Claim as defined in Act 68.