TITLE 41
INSURANCE

CHAPTER 56
PROMPT PAYMENT OF CLAIMS

41-5601. DEFINITIONS. As used in this chapter:

(1) "Beneficiary" means a policyholder, subscriber, member, employer or other person who is eligible for benefits under a contract providing hospital, surgical, or medical expense coverage or a managed care organization policy or agreement under which a third party payer agrees to reimburse for covered health care services rendered to beneficiaries in accordance with the benefits contract.

(2) "Date of payment" means the date the payment is sent as indicated by the mail stamp on the envelope, by the insurer to the practitioner or facility or to the beneficiary in the event there is not a contract for direct payment by the insurer to the practitioner or facility, or, in the event of a wire or other electronic funds transfer, upon acceptance by the insurer's bank of a payment order.

(3) "Department" means the department of insurance.

(4) "Director" means the director of the department of insurance.

(5) "Electronic claim" means a claim that is transmitted through the use of electronic media, which includes the internet, extranet, leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one (1) location to another using magnetic tape, disk or compact disk media. The claim shall contain the proper format and code sets in accordance with the applicable implementation specifications under 45 CFR 160 et seq., and 45 CFR 162 et seq.

(6) "Insurer" means any insurer that sells hospital, medical, long-term care, or vision insurance policies or certificates and managed care organizations. For the purpose of this chapter only, "insurer" also includes a third party administrator who makes payments to beneficiaries, practitioners or facilities on behalf of an insurer and a hospital or professional service corporation that provides hospital, medical, long-term care or vision health care services.

(7) "Practitioner or facility" means any physician, hospital or other person or facility licensed or otherwise authorized to furnish health care services.

(8) "Receipt of claim" means the date the claim is actually received by the insurer from the practitioner or facility or the beneficiary.

(9) "Submission of claim" means the date the claim is sent as indicated by the mail stamp on the envelope, by the beneficiary, practitioner or facility, to the insurer or the date an electronic claim is transmitted to an insurer.

[41-5601, added 2004, ch. 290, sec. 1, p. 812.]

41-5602. PROMPT PAYMENT OF CLAIMS. (1) Except as otherwise specifically provided in this chapter, an insurer shall process a claim for payment for health care services rendered by a practitioner or facility to a beneficiary in accordance with this section.

(2) If a beneficiary, practitioner or facility submits an electronic claim to an insurer within thirty (30) days of the date on which service was

delivered, an insurer shall pay or deny the claim not later than thirty (30) days after receipt of the claim.

(3) If a beneficiary, practitioner or facility submits a paper claim for payment to an insurer within forty-five (45) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than forty-five (45) days after receipt of the claim.

(4) If an insurer denies the claim or needs additional information to process the claim, the insurer shall notify the practitioner or facility and the beneficiary in writing within thirty (30) days of receipt of an electronic claim or within forty-five (45) days of receipt of a paper claim. The notice shall state why the insurer denied the claim.

(5) If the claim was denied because more information was required to process the claim, the notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing. If the practitioner or facility submits the information and documentation identified by the insurer within thirty (30) days of receipt of the written notice, the insurer shall process and pay the claim within thirty (30) days of receipt of the additional information or, if appropriate, deny the claim.

(6) Any claim submitted pursuant to this chapter shall use the current procedural terminology (CPT) code in effect, as published by the American medical association, the international classification of disease (ICD) code in effect, as published by the United States department of health and human services, or the healthcare common procedural coding system (HCPCS) code in effect, as published by the United States centers for medicaid and medicare services (CMS).

(7) This chapter shall not apply to claims submitted under policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, medicare supplement, disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

[41-5602, added 2004, ch. 290, sec. 1, p. 813; am. 2005, ch. 66, sec. 1, p. 231.]

41-5603. INTEREST PAYMENTS. An insurer that fails to pay, request additional information or documentation or deny a claim from a beneficiary, practitioner or facility within the time periods established in this chapter shall pay interest at the contract statutory rate pursuant to section 28-22-104, Idaho Code, on the unpaid amount of a claim that is determined to be due and owing. The interest shall accrue from the date payment was due, pursuant to the provisions of this chapter, until the claim is paid. Payment of any interest amount of less than four dollars ($4.00) shall not be required. Insurers may add any interest due to a future payment to the beneficiary, practitioner or facility.

[41-5603, added 2004, ch. 290, sec. 1, p. 814.]

41-5604. ASSIGNMENT. Nothing in this chapter requires an insurer to accept an assignment of payment by the beneficiary to the practitioner or facility.

[41-5604, added 2004, ch. 290, sec. 1, p. 814.]

41-5605. EXCEPTIONS. (1) The time periods set forth in section 41-5602, Idaho Code, shall not apply to claims that the insurer reasonably believes involve fraud or misrepresentation by the practitioner or facility or the beneficiary or to instances where the insurer has not been provided the information necessary to evaluate the claim after notice has been given requesting additional information by the insurer as required by section 41-5602(5), Idaho Code.

(2) The time periods set forth in section 41-5602, Idaho Code, shall not apply to claims that the insurer reasonably believes require medical records, including accident reports, for the purpose of investigating whether a claim is valid for subrogation, or the coordination of benefits payable by the insurer with benefits payable by another insurer or payable under federal or state law.

(3) An insurer is not required to comply with the time periods set forth in section 41-5602, Idaho Code, if the insurer is in compliance with a contract with the practitioner or facility which specifies different payment requirements. Payments made within the time periods set forth in section 41-5602, Idaho Code, for the purpose of this chapter, shall be deemed to be made in a reasonable and timely manner.

(4) An insurer is not required to comply with the periods set forth in section 41-5602, Idaho Code, if the fee or premium entitling a beneficiary to insurance benefits has not been paid in full.

(5) An insurer is not required to comply with the time periods set forth in section 41-5602, Idaho Code, if failure to comply is due to an act of God, bankruptcy, an act of a governmental authority responding to an act of God or emergency or the result of a strike, walkout or other labor dispute, or act of terrorism.

[41-5605, added 2004, ch. 290, sec. 1, p. 814.]

41-5606. PENALTIES. (1) The director shall enforce the provisions of this chapter and shall review and, if appropriate, investigate complaints received by the department related to noncompliance with the provisions of this chapter.

(2) If the director determines an insurer has violated the provisions of this chapter, the director may impose an administrative fine not to exceed five thousand dollars ($5,000) based upon an enforcement action.

(3) The director shall not suspend or revoke an insurer's certificate of authority for violation of this chapter.

(4) No administrative penalty shall be imposed against an insurer under this chapter or any other provision of law for failure to comply with this chapter if, in the calendar year it has paid ninety-five percent (95%) or more of all claims subject to this chapter to or on behalf of beneficiaries within the time periods set forth in section 41-5602, Idaho Code.

(5) This section shall not create a private cause of action by or on behalf of a beneficiary or practitioner or facility against an insurer.

[41-5606, added 2004, ch. 290, sec. 1, p. 815.]