COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE

March 16, 2006

RULING LETTER NO.: N-PP-3-73-2006

TO ALL DISABILITY INSURERS THAT UNDERWRITE HEALTH CARE PLANS AND HEALTH SERVICES ORGANIZATIONS IN PUERTO RICO

TIMES ESTABLISHED BY LAW NO. 104, ENACTED ON JULY 19, 2002, KNOWN AS THE "LAW FOR THE TIMELY PAYMENT OF CLAIMS TO HEALTH SERVICES PROVIDERS"

Dear Sirs and Madams:

Law No. 104, enacted on July 19, 2002, known as the "Timely Payment of Health Services Provider Claims Act," added Chapter 30 to Law No. 77, enacted on June 19, 1957, as amended, known as the "Puerto Rico Insurance Code", 26 P.R.L.A. secs. 3001 to 3008 (the "Act"). The purpose of the Act is to set time limits for insurers and health services organizations for the payment of health services provider claims, provide a procedure for objecting to claims; and establish penalties for violations of the provisions of the Act.

As expressed in the Statement of Purpose of the Act, late payments, breaches of contract, offers to pay amounts that are lower than the claim amount, and failure to pay due to financial insolvency were some of the problems faced by health services providers that moved the Legislature to establish parameters for the relationship between insurers and health services organizations with health services providers. Likewise, the Legislature sought to stimulate and regulate the timely payment of health services providers without impairing the contractual and property rights the parties may have agreed on, with a view to guaranteeing the best health services for the people of Puerto Rico at large.

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Further to the approval of the Act, the Office of the Commissioner of Insurance (the "OCI") promulgated Rule 73 of the Regulations of the Puerto Rico Insurance Code, for the purpose of establishing the procedures required for the timely payment of claims submitted by domestic health care providers to insurers and health services organizations as provided by Act. This Rule and the substantive portions of the Act entered into effect on January 15, 2003.

Since the Act and Rule 73 came into effect, several concerns have been raised with regard to their scope. For that reason, the OCI issued Ruling Letter No. N-E-3-51-2004, dated March 9, 2004, in which we established guidelines to address the concerns that had been raised up to then.

Notwithstanding the above, the OCI has become aware of situations that certain health services providers are encountering in processing their claims with insurers that underwrite health care plans and health services organizations, which were not foreseen when the Ruling Letter was issued. We have been advised that some insurers and health services organizations have assumed the position of not paying claims that have been submitted after the ninety (90) day period established in Section 30.030 of the Puerto Rico Insurance Code, 26 L.P.R.A. sec. 3002, for a Participating Provider to submit claims for payment for services rendered. In addition, it has been said that the insurers and health services organizations refuse to pay claims when the participating provider has not filed all of the necessary documents or responded to notification from the insurer or health services organization regarding the fact that the claim is unprocessable for payment, within the forty-five (45) day period established in Section 30.050 of the Puerto Rico Insurance Code, 26 P.R.L.A., sec. 3004.

In view of the fact that it is the ministerial duty of this administrative agency, the OCI, to enforce the provisions of the Puerto Rico Insurance and its Regulations[1], we are obligated to establish the parameters to be applied in these situations.

As you all know, Section 30.030 of the Puerto Rico Insurance Code, *supra*, establishes the time periods for the payment of claims to health services providers. In this regard, the Section provides as follows:

> "The participating provider shall submit its claims for payment for services rendered within ninety (90) days after having rendered such services, and the insurer or health services organization is bound to pay in full any processable claim for payment within a term of fifty (50) calendar days, counted from the date that the insurer or health services organization receives the claim.

[1] Section 2.030 (2) of the Puerto Rico Insurance Code, 26 P.R.L.A., sec. 203 (2).

In the event that the insurer or health services organization is the secondary payer, the ninety (90) days shall begin to be counted on the date that the participating provider receives the determination of the primary payer.

After the time periods indicated above have elapsed, the provisions of this chapter shall not be applicable to said claims. Provided that the uniform time period established shall not be construed to render ineffective shorter time periods that may apply to the payment of claims for services rendered, if other alternate payment terms have been agreed on by free contracting." (Our emphasis.)

In addition, Section 30.050 of the Puerto Rico Insurance Code, *supra*, provides, in its relevant portion as follows:

"The insurer or health services organization shall notify the participating providers, in writing or through electronic means, of those claims that are not processable for payment within the term of forty (40) calendar days after receiving the total or partial objection to the claim for payment. The notice shall clearly indicate the reasons for which the insurer or health services organization deems that the claim is not processable for payment, indicating the documents or additional information that must be submitted so that it may be processed.

The participating provider must answer a notice of the insurer or health services organization within the following forty-five (45) days of having received said notice. Failure to do so shall be deemed to be an admission of the deficiencies notified. Once the participating provider submits the required information or documents, the insurer or health services organization shall proceed to pay the claim within the thirty (30) days following the receipt of the information or documents." (Our emphasis)

Likewise and to reiterate the provisions of the sections of the law cited above, Section 4 of Rule 73 provides that: "...**To accept a claim beyond the mutually agreed on ninety (90) day period would imply that the provisions of this Rule and of Chapter 30 of the Code are not applicable."** Likewise it is provided that with regard to the 45-day time period allowed for responding to objections to the payment of a claim "... **Failure to respond to an objection will be deemed to be an admission by the Participating Provider to the objections made in the notice."** (Our emphasis)

Based on the above cited sections of the Law ant the Regulations, the OIC rules that the only consequences for a Participating Provider filing a claim beyond the ninety (90) day term, as established in Section 30.030, *supra*, or any other more

extended period of time as may have been agreed on are: 1) that the health care insurer or Health Services Organization will not have to comply with the timely payment terms; 2) that no interest will be imposed for late payment; and 3) the OIC will not have original jurisdiction on controversies that may arise, which means that in the event of a challenge brought by an insurer authorized to underwrite health care plans or health services organization, the Participating Provider must bring a civil collection action for services rendered at the court of competent jurisdiction.

Furthermore, with regard to the 4-day term provided in Section 30.030, *supra*, for the health services provider to answer objections brought by a health care plan insurer or a Health Services Organization with regard to payment of a claim, we rule that the only effect is on the health services provider. Failure to answer during the aforementioned time period does not indicate acceptance of the objections being notified. It may in no way be interpreted that the provision is depriving the Participating Provider of the right to be paid for health services rendered, if the provider fails to submit all information or documentation required by the insurer or health services organization. Likewise, we are hereby establishing that an affirmative action within a forty-five (45) day period of time by a participating provider, directed at answering an objection made by an insurer or health services organization, constitutes an answer under the provisions of Section 30.050, *supra*, and has the effect of interrupting the time period.

It will only be deemed that the Participating Provider agrees to the contention of the insurer or Health Services Organization that the claim is not processable for payment, when the provider fails to respond in any manner within the established number of days. Even so, the Participating Provider will only be deprived of the safeguards provided under Law No. 104, *supra*, for receiving timely payment for the services rendered, so that the provider should bring action before a court of competent jurisdiction to enforce contractual obligations. Likewise, the insurer or Health Services Organization will not be obligated to abide by the timely payment terms nor be subject to interest for late payment as established in Law No. 104, *supra*.

To interpret that an insurer or Health Services Organization is released from the obligation to pay for health services rendered by a participating provider when the provider has not submitted a claim within the ninety (90) day time period, or has not filed the necessary documents for resolving the claim or responded to an objection, within the forty-five (45) day time period, would be contrary to the clear provisions of the Law and Rule 73. We must emphasize that Law No. 104, *supra*, was enacted with a view to guarantee timely payment of providers for their services. Under no circumstances does this law allow insurers or health services

organizations to waive their obligation to pay, merely because the providers fail to comply with the time periods specified in the Law.

On the other hand, because there are still undecided issues about the applicability of the Law to claims that were in controversy at the time the Law came into effect, it is necessary for this Office to establish guidelines that are applicable to such claims.

The Law clearly applies to all claims that are processable for payment that at the time the Law came into effect had been submitted by participating providers, pending processing, as well as covering any claim in controversy when the law entered into effect.[2] "Claims in controversy" include claims that were adjudicated before the Law came into effect and which, when the Law became effective, were pending review or a controversy existed between the provider and the insurer or health services organization or among providers.

These claims are also subject to payment of applicable interest, as provided in Section 30.070 of the Puerto Rico Insurance Code, which establishes that, "Any processable claim that is not paid within the period of time provided, shall accrue interest [on] for the benefit of the participating provider on the total unpaid amount of said claim or the part thereof that is processable for payment up to the date of its full payment, according to the prevailing legal interest fixed by the Commissioner of Financial Institutions".

Likewise, in the event of any difference or dispute in terms of the amount being claimed, the claim should be processed as provided in Section 30.050, *supra*, regarding "Claims not Processable for Payment." Nevertheless, it will not be considered that a claim is disputed, if the amount the insurer or Health Services Organization has proposed to adjudicate for payment has been agreed on by the parties, regardless of the amount that was invoiced by the provider.

Finally, we have become aware that some insurers and health services organizations have circulated contracts to their health services providers containing clauses that could be contrary to the provisions of the Law. In this regard we are advising you that the contractual relationships established between the health services providers and insurers and health services organizations shall comply with the provisions Law No. 104 and the clear legislative intent. Since the principle of contractual autonomy between the parties is subordinate to the requirement that the agreements, clauses, and conditions may not be contrary to law, the OCI, which has the ministerial duty to administer the provisions of Law No. 104, will not allow insurers that are authorized to underwrite health care

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[2] Section 30.090 of the Puerto Rico Insurance Code, 26 P.R.L.A sec. 3008.

plans or Health Services Organization to use agreements with providers that have the effect of evading the obligations established in the Law.

All disability insurers authorized to underwrite health care plans and all health services organizations in Puerto Rico are required to comply strictly with the provisions of this letter is required by.

Very truly yours,

SIGNED

Dorelisse Juarbe-Jiménez
Commissioner of Insurance