Overview of insurance reimbursement for health care providers

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DFR | Division of Financial Regulation

Department of Consumer and Business Services

Oregon Insurance Code framework

- The Oregon Insurance Code is comprised of ORS Chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750
- The purpose of the Code is “the protection of the insurance-buying public” (ORS 731.008), and it is to be “liberally construed” as to that purpose (ORS 731.016)
- The Code primarily addresses the relationship between insurer and insurance purchaser / consumer
- Some provisions address provider reimbursement, directly or indirectly

ORS Chapter 743A: Reimbursement of Claims

List of provider types that must be reimbursed for specified services

- Osteopaths (018)
- Acupuncturists (020)
- Clinical social workers (024)
- Denturists (028)
- Dentist surgical services (032)
- Expanded practice dental hygienists (034)
- Nurse practitioners & physician associates (036)
- Optometrists (040)
- Physician associates (044)
- Psychologists (048)
- Pharmacists (051)
- Professional counselors & marriage and family therapists (052)

Prompt Pay (ORS 743B.450)

- Health benefit plans must pay or deny a “clean claim” within 30 days
- *“Clean claim” means a claim under a health benefit plan that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.* (OAR 836-080-0080)
- If a health insurance carrier requires additional information, the provider and patient must be notified within 30 days, and the claim must be paid or denied within 30 days of receiving the requested information

Unfair claims settlement practices (ORS 746.230)

- Applies to all lines of insurance
- Prohibits practices that could lead to unfair claim denials or delays, including
  - Misrepresentation
  - Failure to adopt reasonable standards
  - Failure to conduct a reasonable investigation based on all available information
  - Bad faith
  - Requiring submission of redundant and duplicative documentation
- Intended primarily to protect insurance purchasers, but many provisions indirectly protect health care providers or other recipients of claim payments
- ORS 746.233 applies comparable requirements to prior authorization

Other relevant statutes

- Credentialing (743B.454)
  - Insurer must approve or reject credentialing application within 90 days
  - Specifies processes for claims submitted during credentialing period

- Network adequacy (743B.505)
  - Requires insurers to contract with or employ an adequate network of providers to ensure access to covered services without unreasonable delays
  - Prohibits “discrimination with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider’s license or certification in this state”

- External review (743B.252)
  - Adverse benefit determinations may be appealed to independent review organizations

Complaints to DFR

- DFR takes insurance complaints from consumers and other entities that may be subject to violations of the Insurance Code, including health care providers
- DFR can provide a variety of services to complainants ranging from providing informational resources to investigating and taking enforcement action against violations as needed
- If necessary and appropriate, DFR can compel violators to take actions such as paying claims or providing restitution
- For information on the consumer complaint process or to file a complaint, see https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx
- Health care provider complaints are handled via a separate process. Providers are encouraged to contact us via email at HCProvider.Complaints@DCBS.oregon.gov

Questions?

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