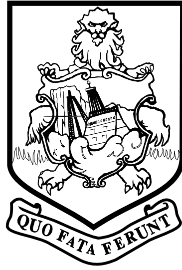

BERMUDA

HEALTH INSURANCE (HEALTH SERVICE PROVIDERS AND INSURERS) (CLAIMS) REGULATIONS 2012

BR 28 / 2012

TABLE OF CONTENTS

PART 1
PRELIMINARY

1 Citation
2 Interpretation

PART 2
DUTY OF HEALTH SERVICE PROVIDER

3 Prohibition against requiring payment of insured portion
4 Submitting a claim
5 Health service provider may apply to require payment of insured portion

PART 3
DUTY OF INSURER

6 Information to health service providers
7 Notice of receipt of a claim
8 Notice of a defective claim
9 Time for paying a claim
10 Application to vary time to pay claims
11 Insurer not required to pay expired claim

PART 4
DUTY OF COUNCIL

12 Council may impose penalty on health service provider
13 Council may impose penalty on insurer
14 Council to pay penalty into Consolidated Fund

PART 5
FINAL PROVISIONS

15 Transitional
16 Commencement

SCHEDULE 1
Data to be Submitted with a Claim

SCHEDULE 2
Information to be Provided by an Insurer

The Minister responsible for health, in exercise of the powers conferred by section 40 of the Health Insurance Act 1970, makes the following Regulations:

PART 1

PRELIMINARY

Citation

1 These Regulations may be cited as the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

Interpretation

2 In these Regulations—

"the Act" means the Health Insurance Act 1970;

"claim" means an electronic claim, unless indicated otherwise;

"clean claim" means a claim submitted by a health service provider which contains the required data and material information which enables an insurer to pay the claim;

"data" means the data referred to in paragraph 4(1)(b) and Schedule 1;

"defective claim" means a claim submitted by a health service provider which is not a clean claim;

"electronic means" means—

(a) an "electronic record" as defined under section 2 of the Electronic Transactions Act 1999;

(b) an electronic data interchange;

"expired claim" has the meaning given in paragraph 11(2);

"health professional" means a person who is registered to practice his or her health profession by the relevant regulatory authority;

"health service provider" means a person, group of persons, or organization that operates a business in Bermuda offering health services to the public, but does not include a person who is an employee under a contract of service;

"insured portion" means that part of the cost of a procedure which is eligible for payment by a person's insurer;

"insurer" means an insurer licensed under section 28 of the Act, and includes the Committee and an employer who operates an approved scheme pursuant to section 26 of the Act;

"notice" means a notice issued by electronic means, unless indicated otherwise;

"procedure" means any clinical service provided by a registered health professional.

PART 2

DUTY OF HEALTH SERVICE PROVIDER

Prohibition against requiring payment of insured portion

3 (1) If a person is insured for a procedure—

(a) a health service provider must not require the person to pay the insured portion of a procedure unless the Council has granted the provider permission to do so pursuant to paragraph 5(5) or paragraph 10(4)(e);

(b) a health service provider must not require the person to pay the insured portion of a procedure where the claim has expired.

(2) A person who is insured may notify the Council in writing where he believes a health service provider has contravened subparagraph (1).

Submitting a claim

4 (1) A health service provider must submit a claim, whether electronic or paper-based, to an insurer—

(a) no later than thirty days from the date on which the procedure was completed; and

(b) which contains all the data referred to in Schedule 1.

(2) Where, after submitting a claim, a health service provider receives a notice from an insurer that the claim is defective, he must submit the data or information required by the insurer under paragraph 8(2)(b) no later than seven days from the date of the notice of a defective claim.

Health service provider may apply to require payment of insured portion

5 (1) A health service provider may apply to the Council for permission to require payment by an insured person of the insured portion of a procedure.

(2) The Council shall not accept an application under subparagraph (1) where—

(a) the insurer has made an application under paragraph 10(1) and—

(i) the Council has granted the application; or

(ii) the application has not as yet been determined by the Council; or

(b) the insurer agrees to make an application under paragraph 10(1).

(3) When making an application under subparagraph (1), the health service provider—

(a) must provide evidence that, with respect to at least five percent of claims submitted to the insurer over a period of three months—

(i) the insurer has failed to pay clean claims by the time prescribed under paragraph 9(1); or

(ii) the insurer has failed to pay clean claims by the time directed by the Council pursuant to paragraph 10(3)(a); and

(b) must provide any documentation or answer any questions which the Council may consider relevant to the application.

(4) The Council may also require the insurer to provide any documentation or to answer any questions which it may consider relevant, including whether the insurer intends to apply to the Council under paragraph 10(1) to vary the time requirement.

(5) In granting permission, the Council—

(a) must specify the period within which the permission has effect; and

(b) may impose such terms and conditions as it deems fit.

PART 3

DUTY OF INSURER

Information to health service providers

6 An insurer must provide the following information to a health service provider at the time of the procedure—

(a) the name, date of birth, and address of—

(i) the person who is the policyholder; and

(ii) any other persons who are insured under the policy;

(b) the policy and group numbers of persons who are insured under the policy;

(c) procedures covered by the insurer; and

(d) the amount of the insured portion of the procedure which is eligible for payment by the insurer.

Notice of receipt of a claim

7 When an insurer receives a claim, he must notify the health service provider of receipt of the claim by the following day.

Notice of a defective claim

8 (1) Where a claim is defective, the insurer must notify the health service provider that the claim is defective no later than seven days from the date of the notice of receipt of the claim.

(2) The notice of a defective claim must contain the following—

(a) a statement explaining the omission or defect which prevents payment of the claim;

(b) the data or material information required to complete the claim or to correct the defect; and

(c) the information required under Schedule 2.

(3) On the date an insurer receives the data or information required to complete or correct a defective claim, the defective claim becomes a clean claim.

Time for paying a claim

9 (1) An insurer must pay a clean claim no later than—

(a) thirty days from the date of the notice of receipt of the claim, where the claim was submitted by the time prescribed under paragraph 4(1)(a); or

(b) ninety days from the date of the notice of receipt of the claim, where the claim was submitted after the time prescribed under paragraph 4(1)(a), provided the claim has not expired.

(2) The date of payment is the date of the instrument of payment.

(3) Upon payment of a claim, the insurer must also provide an explanation of benefits to which the claim relates.

Application to vary time to pay claims

10 (1) An insurer who is unable to pay claims by the time prescribed under paragraph 9(1) may apply to the Council for permission to vary the time requirement.

(2) In determining an application, the Council may require the insurer to provide any documentation or to answer any questions which the Council may consider relevant.

(3) Where permission is granted, the Council—

(a) shall direct the insurer to comply with paragraph 9(1), by the time as varied by the Council;

(b) may impose terms and conditions as it deems fit; and

(c) shall specify the time period within which the permission has effect.

(4) The Council shall notify health service providers—

(a) of the name of the insurer who has been granted permission under subparagraph (3);

(b) of the time in respect of paragraph 9(1) with which the insurer must comply;

(c) of the time period within which the permission has effect;

(d) of any terms and conditions imposed on the insurer, if the Council deems fit; and

(e) that health service providers may require payment by an insured person of the insured portion of a procedure while the permission is in effect.

Insurer not required to pay expired claim

11 (1) An insurer is not required to pay the following—

(a) an expired claim, whether or not it is a clean claim;

(b) a defective claim, where data or information required to complete or correct the claim is submitted 366 days or more from the date the procedure was completed.

(2) In these Regulations “expired claim” means a claim received by an insurer 366 days or more from the date the procedure was completed, and includes a defective claim to which subparagraph (1)(b) applies.

PART 4

DUTY OF COUNCIL

Council may impose penalty on health service provider

12 (1) The Council may impose a penalty on a health service provider in the amount of $500 for each contravention, where the Council has determined that a health service provider required an insured person to pay the insured portion of a procedure—

(a) in contravention of paragraph 3(1);

(b) in contravention of any permission granted under paragraph 5(5).

(2) Where a penalty is unpaid the Council—

(a) shall not register a health service provider under any regulations made under the Bermuda Health Council Act 2004, until such amount is paid; and

(b) may recover the amount as a civil debt in a court of summary jurisdiction.

(3) A health service provider who is aggrieved by the determination of the Council may appeal to the Supreme Court.

Council may impose penalty on insurer

13 (1) The Council may impose a penalty on an insurer in the amount of $500 for each contravention, where the Council has determined that the insurer—

(a) failed to pay a claim by the time prescribed under paragraph 9(1);

(b) failed to comply with any permission granted under paragraph 10(3).

(2) Where a penalty is unpaid the Council—

(a) shall not licence an insurer under the Act until such amount is paid; and

(b) may recover the amount as a civil debt in a court of summary jurisdiction.

Council to pay penalty into Consolidated Fund

14 All sums received by the Council in payment of a penalty shall be paid into the Consolidated Fund.

PART 5

FINAL PROVISIONS

Transitional

15 (1) These Regulations do not apply to claims received by an insurer prior to the Regulations coming into operation.

(2) Notwithstanding paragraph 3(1)(a), the Council may grant permission to a health service provider to require payment of the insured portion of a procedure by an insured person where the Council is of the opinion that it would be unreasonable for the health service provider to comply with paragraph 3(1)(a).

(3) Any permission granted under subparagraph (2) shall expire on such date as the Council shall specify.

Commencement

16 These Regulations come into operation on 1 August 2012.

SCHEDULE 1

(paragraph 4(1)(b))

DATA TO BE SUBMITTED WITH A CLAIM

1. Name of patient
2. Date of birth of the patient
3. Name of insured person
4. Relationship of the patient with the insured person (i.e. self, spouse, child)
5. Address and telephone number of insured person
6. Whether insured person is employed or self-employed
7. Name of insured person's employer
8. Date of the procedure
9. Name of any referring provider
10. Health policy number
11. Certificate number
12. Relevant current diagnostic and procedural code
13. Total fee amount charged
14. Whether the claim is a maternity claim, or the result of a road traffic accident, or a work-related injury
15. Place of service

SCHEDULE 2

(paragraph 8(2)(c))

INFORMATION TO BE PROVIDED BY AN INSURER

1. Name of the health service provider
2. Name of patient
3. Date of the procedure
4. Date claim was received
5. Brief statement of the procedure to which the claim relates, if applicable
6. Whether the claim is clean, defective, or expired
7. Date of payment of the claim
8. Whether claim has been paid, is pending, or has been declined
9. Commentary, if any, in respect of any of the above

Made this 30th day of March 2012

Minister of Health