Trinidad Navarro
Commissioner

Delaware Department of Insurance

Instructions for Filing for and responding to Claims Arbitration under the Department's SB 227/Reg 1319 Arbitration Program

A Provider may request that a Department of Insurance Arbitrator review a claims reimbursement decision made by an Insurance Carrier (*see* 18 *DE Admin. Code* § 1319) **ONLY** if:

1. The reimbursement rate is less than the Medicare reimbursement for comparable physician services;

2. The patient's health care plan is an SB 227-qualifying plan (it is an individual plan issued pursuant to 18 *Del.C.* § 3342B or a group health insurance plan issued under 18 *Del.C.* § 3556A; and

3. The claim in dispute involves either primary care or chronic care management services or both (payment for other services may be contested under other aspects of the Department's arbitration program – see the Department's website for additional information).

CRITICAL DEADLINES:

★ Provider application deadline - **within 60 days** from the date the Provider receives notice from the Insurer of a full or partial denial of reimbursement. Failure to submit the application within the application timeframe will render the Insurer's reimbursement decision final.

★ Insurer response deadline - **within 20 days** of **receipt** of the Petition for Arbitration from the Provider. Failure to do so will result in a summary decision in favor of the Provider.

Use the checklist ON THE NEXT PAGE to ensure that you have completed each step of the process. **A Provider should submit a separate application for each date of service in dispute.**

Each application must be accompanied by a check or money order in the non-refundable amount of **$75.00**. The check or money order must be made payable to "Delaware Insurance Department." On the check, list the full name of the insurance company as indicated on the policy and include the Insurer's NAIC number.

If you have questions, please call the Department toll free at (800) 282-8611 or for local calls (302) 674- 7322. You can also send an e-mail to DOI-Arbitration@delaware.gov.

Delaware Insurance Department
Attn: Arbitration Secretary
1351 West North Street, Suite 101
Dover, DE 19904

Application and Response Checklist

SB 227/Reg 1319 Arbitration Program

*Checklist for a **Medical Services Provider** to petition for arbitration*	*Checklist for an **Insurance Carrier** when responding to a petition for arbitration*
✓ ____ 1. Download Regulation 1319 – Form A-Petition for Primary Care and Chronic Care Management Services Reimbursement Arbitration, and fill it out **COMPLETELY**. To find the insurance carrier's NAIC number, log on to insurance.delaware.gov, click "for Business", click "Active Companies List", click "list of companies." The NAIC number is listed after the name of the insurance company.	✓ ____1. Download Regulation 1319 – Form B Response to Petition for Primary Care and Chronic Care Management Services Reimbursement Arbitration and fill it out **COMPLETELY.**
✓ ____ 2. Determine whether the health insurance plan is an SB 227-qualifying plan as required in the yellow-highlighted box, by referring to the notice of payment determination from the Insurer or by contacting the Insurer.	✓ ____ 2. Be sure to indicate in the yellow-highlighted box whether the health insurance plan is an SB 227-qualifying plan.
✓ ____ 3. Attach all supporting documentation to Form A.	✓ ____ 3. Attach all supporting documentation to Form B.
✓ ____ 4. Send one copy of completed Form A with all supporting documentation to the Insurer or Insurer's representative by certified mail, return receipt requested.	✓ ____ 4. Send one copy of completed Form B with all supporting documentation to the Provider or his or her authorized representative by first class U.S. mail, postage prepaid.
✓ ____ 5. Download and complete Regulation 1319 – Form C Proof of Service of Papers Required for Primary Care and Chronic Care Management Services Reimbursement Arbitration.	✓ ____ 5. Download and complete Regulation 1319 - Form C Proof of Service of Papers Required for Primary Care and Chronic Care Management Services Reimbursement Arbitration.
✓ ___ 6. Send all of the following to the Department at the below address: • The **original** and **one copy** of completed Form A and all supporting documentation; • The completed Form C Proof of Service; and • A check or money order in the non-refundable amount of **$75.00 for each date of service in dispute**.	✓ ___ 6. Send all of the following to the Department at the below address: (the Department may return any non-conforming Response to the carrier): • The **original** and **one copy** of completed Form B and all supporting documentation; and • The completed Form C Proof of Service.