WAC 284-51-215 Time limit. (1) Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC 284-170-431. Primary plans must pay ninety-five percent of clean claims subject to this chapter within thirty calendar days of receipt or of determining they are the primary plan, and must pay all clean claims subject to this chapter within sixty calendar days of receipt or of determining they are the primary plan. Any time limit established by a secondary plan that is in excess of thirty days from receipt of a claim, with the primary plan's explanation of benefit information or other primary payment details needed to process the claim, will be considered unreasonable. The deadlines established in this subsection may be extended for the length of time a primary or secondary plan must wait for information needed from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information), in order to adjudicate the claim.

(2) The specific time limits for coordination of benefits processing include:

(a) When an issuer has been notified that more than one plan covers an enrollee who has submitted a claim, the issuer shall resolve with the other plan in not more than thirty calendar days which plan is primary. This deadline may be extended in situations involving court orders for dependent coverage, if the court order contains information needed to determine which plan is primary and has not been provided to the issuer. If agreement cannot be reached, both plans shall pay as set forth in WAC 284-51-205 (4)(f).

(b) Once the primary plan and secondary plan have been established, if the secondary plan receives a claim without the primary plan's explanation of benefit information or other primary payment details needed to process the claim, including at least the paid amount and the allowed amount, the secondary plan will notify the submitting provider and/or enrollee as soon as possible and within thirty calendar days of receipt of the claim, that the secondary claim is incomplete without such primary plan information. The secondary plan will promptly process the claim after it has been resubmitted with the explanation of benefit information from the primary payer.

(c) If a primary plan has not adjudicated a claim within sixty calendar days of receipt of the claim and all supporting documentation, and if the primary plan is not waiting for information from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information), needed to adjudicate the claim, the provider or enrollee may submit the claim and notice of the primary plan's failure to pay to the secondary plan which shall pay the provider's claim as primary within thirty calendar days.

(3) When payment is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage must be conducted concurrently to avoid delay in the ultimate payment of benefits. Any issuer that is required by the time limit in subsection (2) of this section to make payment as the primary plan may exercise its rights under its "right of recovery" provision for recovery of any excess payments. After payment information is received from the primary plan, the secondary plan may recover any excess amount paid under its "right of recovery" provision.

(4) The provisions in this section do not apply when medicare is the primary payer; in such cases federal medicare law governs.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-51-215, filed 7/6/16, effective 8/6/16. Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.200. WSR 09-16-073 (Matter No. R 2008-20), § 284-51-215, filed 7/30/09, effective 9/1/09; WSR 07-13-008 (Matter No. R 2005-07), § 284-51-215, filed 6/8/07, effective 7/9/07.]