

Prompt Payment Reporting Manual

Kentucky Department of Insurance
Division of Health Insurance Policy and Managed Care

Instructions for Submission of Prompt Payment Report

An insurer, which offers a health benefit plan in Kentucky, is required to file a prompt payment report on a quarterly basis and an insurer, which offers a limited health service benefit plan (LHSBP) with dental-only benefits, is required to file the same report on an annual basis. A prompt payment report must be submitted to the Kentucky Department of Insurance and include the following information:

- (a) The number of clean claims received by the insurer, its agent, or designee during the reporting time frame;
- (b) The percentage of clean claims received by the insurer, its agent, or designee that were:
 1. Adjudicated within the claims payment time frame;
 2. Adjudicated within one (1) to thirty (30) days from the end of the claims payment time frame;
 3. Adjudicated within thirty-one (31) to sixty (60) days from the end of the claims payment time frame;
 4. Adjudicated within sixty-one (61) to ninety (90) days from the end of the claims payment time frame;
 5. Adjudicated more than ninety (90) days from the end of the claims payment time frame; and
 6. Not yet adjudicated;
- (c) The percentage of clean claims received during the reporting time frame that were paid and not denied or contested:
 1. Within the claims payment time frame;
 2. Within one (1) to thirty (30) days from the end of the claims payment time frame;
 3. Within thirty-one (31) to sixty (60) days from the end of the claims payment time frame;
 4. Within sixty-one (61) to ninety (90) days from the end of the claims payment time frame; and
 5. More than ninety (90) days from the end of the claims payment time frame;
- (d) Amount of interest paid; and
- (e) For clean claims received during the reporting time frame that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame.

To demonstrate compliance with KRS 304.17A-722(2):

- Each insurer, which offers a health benefit plan, is required to submit the above data for hospitals, physicians, and all other providers (excluding pharmacy) for each quarter of a calendar year ; and
- Each insurer, which offers a limited health service benefit plan with dental-only benefits, is required to submit the above data for hospital, physicians, dentists and all other providers for a calendar year.

Terms, including adjudicate, clean claim, claims payment time frame, contested claim, and provider, are defined in 806 KAR 17:310, Section 1.

Data must be reported electronically on a 3.5-inch diskette, CD-ROM, or Zip disk, and labeled with the company name, name of report, and reporting time frame. The data must be submitted in a Microsoft Excel spreadsheet and include the following:

- Sheet One (1)- Insurer Identification Information. On this sheet, you will report information relating to your company using alpha numeric values; and
- Sheet Two (2)- Prompt Payment Data. On this sheet, you will report information relating to the payment of claims using numeric values.

All numeric fields must be completed. If there is no data to report for a specific numeric field, zeros shall be used.

A dollar amount must be expressed by using a decimal (.) and carried out two (2) places.

A percentage must be expressed using a number that is carried out two (2) decimal places.

Data submitted to comply with KRS 304.17A-722, shall not be considered complete unless accompanied by a HIPMC-CP-2 (07/2008), the Affidavit, as incorporated by reference in 806 KAR 17:310.

Insurer Identification Information.
 Prompt Payment Report - Sheet One (1)

This sheet, which provides basic identifying information regarding the insurer, shall be submitted as Sheet One (1) of the Excel spreadsheet submitted to meet reporting requirements of KRS 304.17A-722 (1). In the development of Sheet One (1), include the field description and valid values in the respective row and column as listed in the chart. IN REPORTING DIGITS NUMERIC, DO NOT INCLUDE DASHES. Note: The information you report in Column A should be identical to information reported in Column A below. The information you report in Column B should be reported as described in Column B below.

Row	Column A	Row	Column B
Row/ Column	Field Description	Row/ Column	Valid Values
2/A	Insurer name	2/B	Alpha-numeric, maximum 150 characters
3/A	DBA name	3/B	Alpha-numeric, maximum 150 characters
4/A	Reporting time frame	4/B	Must be numeric. This is the 4 digit (month and year) reporting timeframe.
5/A	Contact person	5/B	Alpha-numeric, maximum 150 characters
6/A	Insurer's telephone number	6/B	Must be 10 digits numeric (do not include dashes, etc)
7/A	First line of mailing address	7/B	Alpha-numeric, maximum 150 characters
8/A	Second line of mailing address	8/B	Alpha-numeric, maximum 150 characters
9/A	City	9/B	Alpha-numeric, maximum 150 characters
10/A	State	10/B	Must be 2 digits alphabetic
11/A	ZIP code	11/B	Must be 5 or 9 digits numeric (do not include dashes, etc.)
12/A	NAIC number	12/B	Must be numeric.
13/A	NAIC group number	13/B	Must be numeric.
14/A	Federal tax ID number	14/B	Must be 9 digits numeric (do not include dashes, etc.)
15/A	For clean claims received during the reporting time frame that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	15/B	Must be expressed using a number that is carried out two (2) decimal places.

Prompt Payment Data
 Prompt Payment Report - Sheet Two (2)

This information as required by KRS 304.17A-722 (1) shall be submitted as Sheet Two (2) of the Excel spreadsheet. In the development of this report, you should include the field description and valid value in the respective row and column as listed in the chart. The information you report in Column A on the spreadsheet should be identical to information indicated in Column A below. Each insurer, which offers a health benefit plan, is required to complete only Columns B, C, and D. Each insurer, which offers a limited health service benefit plan with dental-only benefits, is required to complete only Column E.

Row	Column A	Column B	Column C	Column D	Column E
1	Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP – Dental Only
2	Number of Clean Claims received by the insurer, its agent, or designee during the reporting time frame.	B2	C2	D2	E2
3	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within claims payment time frame.	B3	C3	D3	E3
4	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment time frame.	B4	C4	D4	E4
5	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty (31) to sixty (60) days after claims payment time frame.	B5	C5	D5	E5
6	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to ninety (90) days after claims payment time frame.	B6	C6	D6	E6
7	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment time frame.	B7	C7	D7	E7

Row	Column A	Column B	Column C	Column D	Column E
	Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP – Dental Only
8	Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	B8	C8	D8	E8
9	Percentage of Clean Claims received during the reporting time frame that were paid and not denied or contested within the claims payment time frame.				
10	Percentage of Clean Claims received during the reporting time frame that were paid and not denied or contested within one (1) to thirty (30) days from the end of the claims payment time frame.	B10	C10	D10	E10
11	Percentage of Clean Claims received during the reporting time frame that were paid and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment time frame.	B11	C11	D11	E11
12	Percentage of Clean Claims received during the reporting time frame that were paid and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment time frame.	B12	C12	D12	E12
13	Percentage of Clean Claims received during the reporting time frame that were paid and not denied or contested more than ninety (90) days from the end of the claims payment time frame.	B13	C13	D13	E13
14	Amount of interest paid.	B14	C14	D14	E14
15	For Clean Claims received during the reporting time frame that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame.	B15	C15	D15	E15