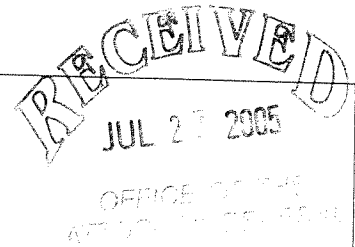


DISTRICT COURT, CITY AND COUNTY OF DENVER,  
COLORADO  
1437 Bannock Street  
Denver, CO 80202



**Plaintiff:**

PACIFICARE OF COLORADO, INC.

v.

**Defendant:**

DOUG DEAN, COMMISSIONER OF INSURANCE, STATE  
OF COLORADO and DIVISION OF INSURANCE,  
DEPARTMENT OF REGULATORY AGENCIES, STATE  
OF COLORADO

▲ COURT USE ONLY ▲

Case Number: 04CV4499

Ctrm: 7

**ORDER**

**(Re: Pacificare's Motion for Partial Summary Judgment and Defendants' Cross Motion for Summary Judgment)**

THIS MATTER is before the Court on Pacificare's Motion for Partial Summary Judgment. Defendants filed a response to the motion and also filed a nearly identical Cross Motion for Summary Judgment. The Court has considered the motions, the responses filed thereto, and the replies, as well as the Court's file and applicable authorities. The Court has also considered the attachments to the respective pleadings and the arguments of counsel presented at the hearing on May 26, 2005. Based on the foregoing, and being sufficiently advised in the premises, the Court finds and orders as follows.

**FACTUAL BACKGROUND**

The underlying facts are undisputed. In late 2002 and early 2003, the Division of Insurance (hereafter the Division) conducted a Market Conduct Examination of Pacificare of Colorado, Inc. (hereafter Pacificare) pursuant to C.R.S. section 10-1-201, *et seq.* As a result of the examination, in August 2003 the Division issued a Final Agency Order identifying the failure by Pacificare in some cases to pay interest on certain clean claims not paid within thirty days and other claims not paid within forty-five days. Prior to and following the issuance of the FAO, the Division and Pacificare communicated regarding the correct interpretation of the Prompt Pay Act, particularly as to the applicability of section 10-16-106.5 to clean claims that

were initially processed in a timely fashion by Pacificare but were then later adjusted. In those communications, Pacificare asserted that the interest and penalties set forth in section 10-16-106.5 are not payable on adjustments, even when the adjustment was a result of Pacificare's error, and that applicable interest and penalties are payable only when the original decision to pay, deny or settle a claim was not made within the appropriate timeframes. The Division disputed and ultimately rejected Pacificare's interpretation of section 10-16-105.6 in a letter from the then Director of Compliance, which affirmed the Division's position that the late payment interest and penalties provided by the act are due on adjustments that are paid or settled beyond the required time periods when the company did not pay the initial claim correctly. Pacificare thereafter commenced the instant action on June 11, 2004.

### STANDARD OF REVIEW

Under C.R.C.P. 56(c), summary judgment is proper only if the pleadings and supporting documents establish that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *Civil Serv. Comm'n v. Pinder*, 812 P.2d 645, 649 (Colo. 1991). The moving party bears the burden of establishing the non-existence of a genuine issue of material fact. If the moving party meets that initial burden, the burden then shifts to the nonmoving party to establish that there is a triable issue of fact. *Cont'l Air Lines, Inc. v. Keenan*, 731 P.2d 708, 712-13 (Colo. 1987). However, the interpretation of statute is a question of law, *Arnold v. Colorado Department of Corrections*, 978 P.2d 149 (Colo. App. 1999), and cases involving only the legal construction of a statute are appropriately resolved on summary judgment. 10A Fed. Prac. & Proc. Civ. 3d § 2725 (1998). Here, based upon the cross-motions for summary judgment, the parties agree that dispositive issue is the correct interpretation of the Prompt Pay Act, which is an issue that may properly be resolved on summary judgment.

### ANALYSIS

In construing statutory provisions, the Court must give effect to the intent of the General Assembly by first looking to the statutory language itself, giving words and phrases their commonly accepted and understood meaning. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The plain language of a statute is the best indication of legislative intent, and as long as the meaning is unambiguous the court need not resort to interpretive rules of statutory construction such as the legislative intent or the external circumstances at the time the statute was enacted. *Town of Telluride v. Lot Thirty-Four Venture, L.L.C.*, 3 P.3d 30 (Colo. 2000). Words and phrases utilized in a statute must be given effect according to their plain and ordinary meaning because courts must presume that the General Assembly meant what it said. *PDM Molding*, 898 P.2d at 545; *Allstate Ins. Co. v. Smith*, 902 P.2d 1386 (Colo. 1995). A statute should be interpreted so that no clause, sentence, or word is rendered superfluous, contradictory, or insignificant. *Arnold*, 978 P.2d at 151. Statutes that are part of a single scheme or that deal with the same subject should be construed harmoniously. *Left Hand Ditch Company v. Hill*, 933 P.2d 1 (Colo. 1997). When the General Assembly adopts a comprehensive regulatory program, the legislation should be construed as a whole, giving consistent, harmonious and sensible effect

to all of its parts in the context of the entire scheme. *Id.*, 933 P.2d at 3; *Martinez v. People*, 69 P.2d 1029, 1033 (Colo. 2003).

The Prompt Payment Act, as codified in C.R.S. § 10-16-106.5, was enacted to impose reasonable standards upon insurance carriers for the timely payment of health care claims. C.R.S. § 10-16-106.5(1)(b). The Act is premised upon the legislative declaration that:

Patients and health care providers often do not receive the reimbursements to which they are entitled from health insurance entities in a timely manner, even in the case of claims that are submitted on standard forms and do not require additional information for processing; and

Unnecessary delays in the payment of routine and uncontested claims for reimbursement represent an unwarranted drain on health care providers' resources, which could be better spent attending to the needs of patients, as well as wasting the time and money of the patients themselves.

C.R.S. § 10-16-106.5(1)(a) and (b). The Act requires that “clean claims” be “paid, denied, or settled” within thirty calendar days after receipt of the claim by the carrier if it is submitted electronically and within forty-five calendar days after receipt by the carrier if it is submitted by any other means. C.R.S. § 10-16-106.5(4)(a). A “clean claim” is a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form with all required fields completed with correct and complete information, including all required documents.<sup>1</sup> C.R.S. § 10-16-106.5(2). A carrier that fails to “pay, deny, or settle” a clean claim in accordance with the applicable time frames is liable for the covered benefit and, “in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due . . . .” C.R.S. § 10-16-106.5(5)(a). The Act does not “prohibit a carrier from retroactively adjusting payment of a claim that is not subject to the provisions of section 10-16-704” so long as the policyholder notifies the carrier of a change in eligibility of an individual” and “the adjustment is made within thirty days after the carrier’s receipt of such notification.” C.R.S. 10-16-106.5(6)(a) and (b).

In the instant action, both parties assert, and the Court agrees, that the provisions of section 10-16-106.5 are unambiguous. The Court must therefore turn to and rely upon the plain language of the statute. Pacificare asserts that the statute on its face does not require the payment

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<sup>1</sup> If additional information is necessary to pay, deny or settle a claim, the Act provides the time frames in which to request and obtain that information. *See* C.R.S. § 10-16-106.5(4)(b). The carrier is required to provide an explanation of the additional information needed, places the onus on the provider to supply the requested information within 30 days of the request, and permits the carrier to deny the claim if the provider does not timely provide the information. *Id.* Absent fraud, the Act requires carriers to pay, deny or settle claims on which additional information was requested within 90 days of the original receipt of the claim. C.R.S. § 10-16-106.5(4)(c).

of interest or penalties “where a claim is initially paid, denied or settled in a timely fashion but an adjustment is later made by the provider or the carrier.” [PacifiCare’s Motion at 11]. Thus, PacifiCare argues, if an amount is paid by a carrier on a clean claim within the applicable 30 or 45 day time period, regardless of whether that amount was “in full” or “in part,” no interest or penalty may be assessed if the claim is later adjusted beyond the statutory 30 or 45 day time period. To this end, PacifiCare asserts that the term “pay” or “paid,” within the context of section 10-16-106.5, does not mean “pay in full” but necessarily includes “mis-pay, under pay, and overpay.” [PacifiCare’s Brief in Opposition at 3]. Defendants assert that the plain language of the statute demonstrates the legislative intent that carriers pay the total amount due on clean claims within the applicable time periods or face the imposition of interest and penalties, regardless of whether a claim is subsequently adjusted. The Court agrees with Defendants.

The plain and ordinary meaning of the term “pay” is to give that which is due and owing to discharge or settle a debt, obligation or expense. *See Webster’s New World Dictionary* (1976). The definition suggests full resolution of a debt or obligation, and is consistent with the Prompt Payment Act’s legislative declaration that patients and health care providers often do not receive the prompt reimbursements “to which they are entitled . . . .” C.R.S. § 10-16-106.5(1)(a). It is also consistent with the statutory scheme established by the Act. By definition, a clean claim is one in which the carrier has all the necessary information required for it to make a decision as to the claim’s final disposition. Thus, upon receipt of such a claim, the statute requires the claim to be timely “paid, denied, or settled.” These terms, individually and in conjunction with each other, connote not simply the initiation of a process but rather *resolution* of the claim. In the Court’s view, the statute’s plain language demonstrates the legislative intent that the “routine and uncontested” claims subject to section 10-16-106.5 be resolved in full within the applicable time frames.

PacifiCare’s assertion that “payment” constitutes remittance of *any* amount towards a claim within the statutory time period, subject to an indefinite “adjustment” without interest or penalty should the amount tendered prove to be insufficient or incorrect, is contrary to the final resolution required by the statute. PacifiCare’s position is also contrary to the expressed legislative intent to eliminate “unnecessary delays” and to foster the reimbursement to patients and providers of the amounts to which they are entitled. C.R.S. 10-16-106.5(1). The Court therefore concludes that the term “pay” within the context of the Prompt Payment Act, contemplates the timely payment of the full amount due on claims properly submitted to a carrier, and that claims not so paid are subject to interest and penalty regardless of whether the claim may be subsequently adjusted by the carrier.

The Court further concludes that the statutory provisions permitting the adjustment of claims under certain conditions does not modify a carriers’ liability for interest and penalty for failure to timely pay clean claims as required by section 10-16-106.5. Section 10-16-106.5(6) permits the retroactive adjustment of a claim in the limited situation in which policyholder notifies the carrier of a change of an individual’s eligibility, provided the adjustment is made within thirty days after the carrier is notified of the change. Section 10-16-704 provides that all claims paid by carriers are considered final unless adjusted pursuant to certain specific

circumstances enumerated within the provision.<sup>2</sup> None of the provisions expressly or by implication modify or limit the carrier's obligations and liabilities for untimely payment as set forth in Section 10-16-106.5. It does not follow, as suggested by Pacificare, that the provisions permitting adjustments under certain circumstances without interest or penalty under sections 10-16-106.5(6) or 10-16-704 necessarily eliminate a carrier's liability for interest and penalty on untimely claims not subject to the specific adjustments (and time frames) set forth in the statute. Thus, absent the applicability of a circumstance enumerated in the statute, a carrier's adjustment of a mis-paid claim outside the time frames prescribed by section 10-16-106.5 subjects the carrier to liability for interest and penalty in accordance with section 10-16-106.5(5)(a). To adopt Pacificare's contrary position that a carrier may adjust a claim, essentially for any reason and at any time so long as some remittance is made within the statutorily prescribed time frame, would not only render meaningless the Act's interest and penalty provisions, but, as previously discussed, would necessarily undermine the legislative intent and purpose of the Act as a whole.

### CONCLUSION

The Court therefore concludes that the clear and ambiguous language of the Prompt Payment Act requires payment in full within the statutorily prescribed time frames on clean claims submitted pursuant to section 10-16-106.5 and, absent the limited exceptions specified in sections 10-16-106.5(6) and 10-16-704, late payment interest and penalties are due on adjustments that are paid or settled beyond the required time periods when the carrier did not pay the initial claim correctly based on all information available when the claim was processed.

Accordingly, Defendant's Motion for Summary Judgment is granted, and Plaintiff's Motion for Partial Summary Judgment is denied. Judgment is herein entered in favor of Defendants and against Plaintiff. The Court further concludes that Defendants' concession that its Letter of May 14, 2004 is not a rule and would not be enforced as a rule renders Plaintiff's Second Claim for Relief moot. The bench trial currently scheduled in this action is therefore vacated, and this action is dismissed with prejudice.

SO ORDERED this 22 day of July, 2005.

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<sup>2</sup> Sub-sections (b) through (e) set the maximum time limits for the adjustments permitted by section 10-16-704. Sub-section (f) prohibits retroactive adjustment if the carrier verified the individual's eligibility within two days of the service. Subsections (g) and (h) relate to premiums not being received during the premium payment grace period. Sub-section (i) authorizes retroactive adjustments in favor of the carrier if the enrollee was not eligible on the date the service was provided or if the enrollee committed fraud on the application for coverage or in applying for benefits. Sub-section (k) states that the statute does not require HMO's to give a premium grace period. Sub-section (l)(I) relates to carrier overpayments and (l)(II) relates to coordination of benefits, which usually involves a reduction in the carrier's liability. Sub-section (m) relates to adjustment of claims as a result of fraud or abuse by a provider.

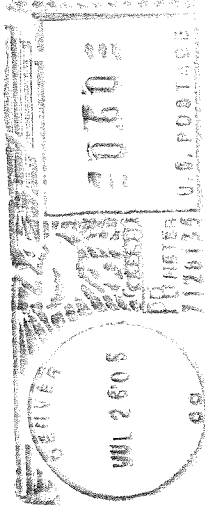
**BY THE COURT:**

A handwritten signature in black ink, appearing to read "Martin F. Egelhoff", written over a horizontal line.

**Martin F. Egelhoff**  
**District Court Judge**

cc: Charles Hecht, Esq.  
Christine Stretesky, Esq.

CHAMBERS  
**District Court**  
CITY AND COUNTY BUILDING  
DENVER, COLO. 80202  
Martin F. Egelhoff, Judge



CHRISTINE C. STRETESKY  
ASSIST. ATTY. GEN.  
1525 SHERMAN ST., 5<sup>TH</sup> FLOOR  
DENVER, CO 80203

60203+1714-55 0044

