

Prompt-Pay Statutes – 50 States

Appendix A

ALABAMA (Ala. Code § 27-1-17.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 27-1-17(a).

Penalties: 1.5% per month interest; fines up to \$1,000 for each day unpaid, not to exceed \$100,000 per violation. Interest is prorated daily; accrues from date overdue; payable at claim payment. § 27-1-17(c).

Other Stipulations: Notice of information is needed within 30 days; pay/deny within 21 days after receipt of information. § 27-1-17(a).

Premium Delinquency Exception/Grace Period: Matters beyond control & related directly or indirectly to the processing of claims. § 27-1-17(d)(1)(c).

Fraud and Abuse Provisions Exception: When investigation has been reported to a state or federal agency or an external review process. § 27-1-17(d)(3)(j).

Provider Timely Filing: 180 days after service rendered. § 27-1-17(d)(2).

Adjustments/Refunds/Recoupment: One year from earlier of (1) initial claim payment or (2) expiration of the provider claim filing. § 27-1-17(e)-(i). Exceptions include Medicaid and Medicare, excluding Med+C. § 27-1-17(k).

ALASKA (Alaska Stat. §§ 06.40.120, 21.36.495, 21.54.020.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 21.36.495(a)-(b).

Penalties: 15% per annum. §§ 06.40.120, 21.36.495(c)-(d).

Other Stipulations: Group plans only (1) without notice of defects in 30 days, assumed clean or (2) with notice of defects must be paid within 30 days of receipt of claim or 15 days after receipt of information. Non-group claims must be paid within 30 days with notice of acceptance or denial within 15 days. § 21.36.495(d).

Premium Delinquency Exception/Grace Period: NAIC Model.

Fraud and Abuse Provisions Exception: A clean claim is defined as a claim without a defect, impropriety, or circumstance requiring special treatment that precludes timely payment. § 21.36.495(i)(1).

Adjustments/Refunds/Recoupment: Does not prohibit a health care insurer from recovering an amount mistakenly paid to a provider or covered person. § 21.54.020(d).

ARIZONA (Ariz. Rev. Stat. Ann. §§ 20-220, 20-1347, 20-3101 to 20-3102.)

Applies to “clean claims” only; electronic claims must be paid in 60 days; written claims must be paid in 60 days. § 20-3102.

Penalties: Interest accrues from 10% one day after the payment is due. General penalties are \$1,000 per violation, not to exceed \$10,000 per six-month period and \$5,000 per intentional violation, not to exceed \$50,000 per six-month period. § 20-220(B).

Other Stipulations: Timeframe is bifurcated; 30 days to approve/deny clean claims and another 30 days after approval to pay. Notice of information is needed within 30 days; pay/deny within 21 days after receipt of information. § 20-3102.

Premium Delinquency Exception/Grace Period: Group/Blanket Disability—policy continues in force during grace period. § 20-1347.

Fraud and Abuse Provisions Exception: Clean claim is defined as a written or electronic claim that can be processed without obtaining additional information, including coordination of benefits, except in cases of fraud. §§ 20-3101(2), 20-3102(I).

Adjustments/Refunds/Recoupment: Except in cases of fraud, a health care insurer or health care provider shall not adjust or require adjustment of the claim more than one year after the health insurer has paid that claim. § 20-3102(I).

ARKANSAS (Ark. Code Ann. § 23-66-215.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days.

Penalties: 12% per year beginning on the 61st day after receipt of clean claim; 12% per year on the 46th day after receipt of other claims.

Other Stipulations: Request information within 30 days; pay/deny within 30 days of receipt of information. From the date of clean claim receipt, or receipt of needed information, to the date of adjudication, interest penalty calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquency payment period divided by 365.

Fraud and Abuse Provisions Exception: If information is needed to determine if there has been a fraud or a fraudulent or material misrepresentation with respect to the claim, a health carrier shall within 30 days after the receipt of the claim, notify the health claimant and shall give an explanation.

Adjustments/Refunds/Recoupment: 18-month period after the date the claim was paid; written notice required. Exceptions include coverage verification error and fraud.

CALIFORNIA (Cal. Ins. Code §§ 10123.13, 1371, AB 1455; Cal. Code Regs. tit. 28, § 1300.71.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 business days; written claims must be paid in 30 business days. § 10123.13.

Penalties: 15% per year; late payment on emergency care must include the greater of \$15 for each 12-month period on a non-prorated basis or 15% per year; \$10 penalty for not including interest payment with late claims payment. § 10123.13.

Fraud and Abuse Provisions Exception: Time for reimbursement of complete claim does not apply to claims about which there is evidence of fraud misrepresentation. § 1371.35.

Adjustments/Refunds/Recoupment: 365 days after the date the claim was paid; written notice required. Exceptions include fraud, wherein the provider shall reimburse the health plan within 30 working days of receipt of the notice, unless contested by the provider; if the provider does not make reimbursement, interest shall accrue at the

rate of 10% per annum beginning with the first calendar day after the 30-working day period. §§ 10123.145, 10133.66(b); Cal. Health & Safety Code § 1371.1; Cal. Code Regs. tit. 28, 1300.71(b)(5), (d)(3)-(6).

COLORADO (Colo. Rev. Stat. § 10-16-106.5.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 10-16-106.5(4)(a).

Penalties: 10% per year; after 90 days an extra penalty of 10% of the total amount of the claim is added. § 10-16-106.5(5)(a)-(b).

Other Stipulations: Request information needed within 30 days; provide requested information within 30 days; pay/deny/settle within 90 days after receipt of claim. § 10-16-106.5(5)(b).

Premium Delinquency Exception/Grace Period: Clean claim does not include a claim for payment incurred during a period for which premiums are delinquent, except as otherwise required by law. § 10-16-106.5(2).

Fraud and Abuse Provisions Exception: The 90-days time for paying claims for which additional information is needed does not apply in cases involving fraud. § 10-16-106.5(4)(c).

Adjustments/Refunds/Recoupment: Retroactive adjusting payment of a claim if the policyholder notifies the carrier of a change in eligibility of an individual and the adjustment is made within 30 days after the carrier’s receipt of such notice. § 10-16-106.5(6).

CONNECTICUT (Conn. Gen. Stat. § 38a-816.)

Applies to “clean claims” only; electronic claims must be paid in 45 days; written claims must be paid in 45 days. § 38a-816.

Penalties: 15% per year. § 38a-816.

Other Stipulations: Request information needed within 30 days; pay/deny within 30 days after receipt of information. § 38a-816.

Fraud and Abuse Provisions Exception: Except when the claimant has fraudulently caused or contributed to the loss. § 38a-816(15)(A).

DELAWARE (Del. Ins. Reg. 1310 § 1.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: Maximum rate for allowable to lenders under tit. 6, § 2301(a).

Other Stipulations: Request information needed within 30 days; pay/deny within 15 days after receipt of information.

Premium Delinquency Exception/Grace Period: NAIC Model. Tit. 18, § 3307.

Fraud and Abuse Provisions Exception: Reg. 80, § 5.

Provider Timely Filing: Proof of loss must be submitted within 90 days after the date of loss. Failure to do so does not invalidate or reduce the claim, if not reasonably possible to give proof and was furnished as soon as reasonably possible. Tit. 18, § 3311, 3522.

DISTRICT OF COLUMBIA (D.C. Code §§ 31-3131 to -3136.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 31-3132.

Penalties: 1.5% per month for claims paid between 31-60 days after receipt; 2% for claims paid between 61-120 days; 2.5% for claims paid after 120 days. § 31-3132(c).

Other Stipulations: Request information is needed within 30 days; pay/deny within 30 days after receipt of information. § 31-3132.

Premium Delinquency Exception/Grace Period: Indemnity—§ 31-3512(1). HMO—§ 31-3407(a)(2)(W).

Fraud and Abuse Provisions Exception: § 31-3133(b)(2)(A).

Provider Timely Filing: 180 days from the date a covered service is rendered or the date of inpatient discharge to submit a claim for reimbursement. § 31-3132(g).

Adjustments/Refunds/Recoupment: Retroactively deny reimbursement (1) for coordination of benefits, 18-month period after the date that the health insurer paid the health care provider and (2) during the six-month period after the date that the health insurer paid the health care provider. Exceptions apply for information submitted to the health insurer that was fraudulent, improperly coded, or duplicate claims. §§ 31-3133(a)-(b), 31-3136.

FLORIDA (Fla. Stat. §§ 641.3155, 627.6131.)

Applies to “clean claims” only; electronic claims must be paid in 20 calendar days; written claims must be paid in 40 calendar days.

Penalties: 12% per year on the 21st day after receipt of clean electronic claims; 12% per year on 41st day after receipt of clean non-electronic claims; 12% per year on 91st day after receipt of unclean or contested electronic claims.

Other Stipulations: Notice of acknowledgement with 24 hours for electronic claims and 15 days for non-electronic claims; request information needed within 45 days; pay/deny contested claims within 60 days after receipt of information; all claims must be paid/denied within 120 days of receipt of claim. Section 627.613 provides 45 calendar days for payment and 10% interest penalty for subscriber submitted claims not paid promptly.

Premium Delinquency Exception/Grace Period: Grace period. NAIC Model. § 627.608.

Fraud and Abuse Provisions Exception: A claim for overpayment shall not be permitted beyond 30 months after the health maintenance organization’s payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to §§ 817.234, 641.3155(5)(b).

Provider Timely Filing: Must be mailed or electronically transferred within six months after discharge for inpatient services or the date of service for outpatient services. § 641.3155(2)(b).

Adjustments/Refunds/Recoupment: Overpayment must be submitted to a provider (MD, DO, Chiropractor, Podiatrist, and Dentist) within 12 months of the insurer or HMO’s payment of the claim. Overpayment requests must be submitted for facility claims within 30 months after the insurer or HMO’s payment of the claim. An

underpayment request period is limited to 12 months after the insurer or HMO's payment of the claim for MD, DO, Chiropractor, Podiatrist, and Dentist. ASO groups are excluded. §§ 627.6131(6), (11), 641.3155(5), (10).

GEORGIA (Ga. Code Ann. §§ 33-24-59.5, 33-29-3(b)(8), 33-30-6(b)(5).)

Does not apply to "clean claims" only; electronic claims must be paid in 15 business days; written claims must be paid in 30 business days.

Penalties: 12% per year based on amount paid, not days late.

Other Stipulations: Request information needed within 15 days; pay/deny within 15 days after receipt of information; a denied claim could assess a penalty of \$5,000 if not denied within 15 business days.

Premium Delinquency Exception/Grace Period: Individual—§ 33-29-3 (b)(3). Group, including PPO—§ 33-30-4. NAIC Model.

Provider Timely Filing: NAIC Model. § 33-29-3(b)(5).

HAWAII (Haw. Rev. Stat. §§ 431:10A-105(5)(A), 431:13-108.)

Does not apply to "clean claims" only; electronic claims must be paid in 15 calendar days; written claims must be paid in 30 calendar days. § 431:13-108(b)-(e).

Penalties: 15% per year on all measures; interest accruing in a sum of \$2.00 on a clean claim added to unpaid claim amount. § 431:13-108(h).

Other Stipulations: Contested/request for additional time notification is seven days electronic or 15 days non-electronic; specified information is needed in notice; notice is not required if reimbursement report is sent to provider monthly; pay/deny within seven days of receipt of information electronically or 30 days of receipt of information in writing. § 431:13-108(b)-(e).

Premium Delinquency Exception/Grace Period: NAIC Model. Does not include (1) claims for payment of expenses incurred during a period of time when premiums were delinquent or (2) Individual Health and Accident. Grace period. § 431:13-108(l).

Fraud and Abuse Provisions Exception: Does not include claims submitted fraudulently or that are based upon material misrepresentations. § 431:13-108(l).

Provider Timely Filing: Individual Health and Accident. NAIC Model. § 431:10A-105(5)(A).

IDAHO (Idaho Code §§ 228-22-104, 41-5601 to -5606.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 41-5602.

Penalties: 12% per year. § 28-22-104.

Other Stipulations: Interest under \$4.00 is excluded; additional information requested within 30 days must be returned by the provider within 30 days, not to exceed 90 days. If less than 95% of claims were paid promptly to an individual or provider, there is a possible flat fee of \$5,000. § 41-5603, -5606.

Premium Delinquency Exception/Grace Period: Insurer is not required to comply with the periods set forth, if the fee or premium entitling a beneficiary to insurance benefits has not been paid in full. § 41-5605(4).

Fraud and Abuse Provisions Exception: The time periods set forth shall not apply to claims that the insurer reasonably believes involve fraud or misrepresentation by the practitioner or facility or the beneficiary. § 41-5605(1).

Provider Timely Filing: Electronic claim within 30 days of the date on which service if a paper claim within 45 days of the date on which service. § 41-5602(2).

ILLINOIS (215 Ill. Comp. Stat. 5/357.9, 357.9a, 368a.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days.

Penalties: 9% per year.

Other Stipulations: Applies to all claims after receipt of written proof of loss.

Premium Delinquency Exception/Grace Period: NAIC Model. 215 ILCS 5/357.4.

Provider Timely Filing: NAIC Model. 215 ILCS 5/357.6.

Adjustments/Refunds/Recoupment: Recoupments permitted within 18 months of original payment, except for fraud or close of business. 215 Ill. Comp. Stat. 5/368d; Ill. Admin. Code tit. 50, §§ 2602.40, .50.

INDIANA (Ind. Code §§ 5-10-8.1, 12-15-27-3, 27-8-5-19, 27-8-5.7-6 to -8, 27-13-36.2.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. §§ 5-10-8.1-6, 27-8-5.7-6.

Penalties: 2% per year. § 12-15-27-3(7)(A).

Other Stipulations: Request information is needed within 30 days electronically or 45 days written. Civil penalties based on percent of claims paid timely in a calendar year are (1) up to \$10,000 for 85-95%, (2) up to \$100,000 for 60-84%, and (3) up to \$200,000 for less than 60% of the claims are paid timely. § 27-8-5.7-8.

Premium Delinquency Exception/Grace Period: NAIC Model. § 27-8-5-19(c)(1).

Provider Timely Filing: NAIC Model. § 27-8-5-19.

Adjustments/Refunds/Recoupment: Within two years period after the date the claim was paid; written notice required. Exceptions include fraud. §§ 27-8-5.7-10 to -11, 27-13-36.2-8 to -9.

IOWA (Iowa Code §§ 507B.4, 507B.4A, ICA 191-15.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 10% per year after the 30th day.

Other Stipulations: Applies to all claim types. Excluded claim types include FEP, BlueCard HOME and HOST, ERISA self-funded non-governmental bodies, history postings, and zero paid claims. Clean claims do not include claims that involve close of business, preexisting condition investigations, subrogation, or fraud.

Premium Delinquency Exception/Grace Period: For group-sponsored health plans, the failure to pay premiums in a timely manner would reasonably prevent an insurer from paying an otherwise clean claim within 30 days. § 507B.4A.

Fraud and Abuse Provisions Exception: Excludes claims with circumstances requiring special treatment, such as fraud or a material misrepresentation, from prompt payment requirements. § 507B.4A.

KANSAS (Kan. Stat. Ann. § 40-2440.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 1% per month on all measures.

Other Stipulations: Pay/deny within 15 days after information receipt; applies to host claims when Kansas City Plan is the home plan and the member lives in Johnson County or Wyandotte County in Kansas.

Premium Delinquency Exception/Grace Period: NAIC Model. § 40-2203(A)(3).

Fraud and Abuse Provisions Exception: Provisions do not apply when the legitimacy of the claim is questionable, or claim was submitted fraudulently. § 40-2442(e).

Provider Timely Filing: NAIC Model. § 40-2203(A)(5).

KENTUCKY (Ky. Rev. Stat. Ann. §§ 304-17-070, 304.17A-700 to -722.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 304.17A-702.

Penalties: 12% per year for claims paid between 1-30 days after payment is due; 18% per year for claims paid between 31-60 days after payment is due; 21% per year for claims paid over 90 days after payment is due. § 304.17A-702(1), -706.

Other Stipulations: Notification of information needed within 30 days; pay/deny within 30 days after information receipt; per calendar quarter, less than 95% clean claims or less than 90% of paid claim dollar amount paid timely, the greater of \$1,000 per day or 10% of unpaid claim amount fine per day; fines up to \$10,000 for willful violations or pattern of repeated violations. § 304.17A-722.

Premium Delinquency Exception/Grace Period: NAIC Model. §§ 304.17-070, 304.17A-243.

Fraud and Abuse Provisions Exception: Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the 24-month period after the date that the insurer paid the claim submitted by the provider. § 304.17A-708(3)(a).

Provider Timely Filing: NAIC Model. § 304.17-090-110.

Adjustments/Refunds/Recoupment: Miscalculations in payments made by the insurer must be corrected and paid within 30 calendar days; after 24 months from payment date, insurer shall not correct payment errors upon provider’s request. Claim refunds and overpayments—requires written notice to provider of payment made for services for an individual who was not eligible, and (1) request a refund from the provider or (2) make a recoupment of the overpayment from the provider. § 304.17A-708, -712.

LOUISIANA (La. Stat. Ann. § 22:1832 to 1860.)

Does not apply to “clean claims” only; electronic claims must be paid in 25 days; written claims must be paid in 45 days. § 22:1853.

Penalties: 12% per annum of amount due; administrative penalties up to \$1,000 per violation, not to exceed \$100,000 in aggregate; if the insurer knew or should have known, penalties up to \$25,000, not to exceed \$250,000 in aggregate in a six-month period. § 22:1860.

Other Stipulations: Within five working days from electronic claim receipt, insurer must review and notify provider of defects or reasons claim is not accepted; resubmitted claims must be paid/denied/pended within 60 days of claim receipt date. § 22:1832.

Fraud and Abuse Provisions Exception: Exception to prompt payment time frames in cases of fraud. § 22:1832.

Provider Timely Filing: Electronic Claims. Pay within 45 days of receipt, provider submitted within 45 days of date of service; pay within 60 days of receipt, any claim submitted more than 45 days after the date of service. § 22:1832.

Adjustments/Refunds/Recoupment: Recoupment of health insurance claims payments permitted. § 22:1859.

MAINE (Me. Stat. tit. 24-A, §§ 2436, 2707, 2823, 4222-B, 4303.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. §§ 2436(1), 4222-B.

Penalties: 1.5% per month after the due date on claims that are unpaid or undisputed. § 2436(3).

Other Stipulations: Request information needed within 30 days; pay/deny within 30 days after receipt of information. § 2436(1-A).

Premium Delinquency Exception/Grace Period: NAIC Model. § 2707.

Provider Timely Filing: NAIC Model. § 2823.

Adjustments/Refunds/Recoupment: May only retroactively deny reimbursement during the 18-month period after the date that the carrier paid the health care provider. Exceptions apply for fraud. § 4303(10).

MARYLAND (Md. Code Ann., Ins. §§ 15-209, -1005 to -1008.)

Applies to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. § 15-1005(c).

Penalties: 1.5% per month from the 31st to 60th day; 2% from the 61st to 120th day; 2.5% after the 120th day. § 15-1005(f).

Other Stipulations: Applicable when CareFirst BCBS of MD is a Host for DC members. When additional information is needed, it must be requested within 30 days. § 15-1005.

Premium Delinquency Exception/Grace Period: § 15-209.

Fraud and Abuse Provisions Exception: Exceptions apply if a carrier retroactively denies reimbursement to a health care provider because the information submitted to the carrier was fraudulent. § 15-1008(e).

Provider Timely Filing: 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service. § 15-1005(d)(1).

Adjustments/Refunds/Recoupment: Retroactively deny reimbursement for coordination of benefits during the 18-month period after the date that the carrier paid the health care provider; may only retroactively deny reimbursement during the six-month period after the date that the carrier paid the health care provider. Exceptions apply for fraudulent or improperly coded information or duplicate claims. § 15-1008.

MASSACHUSETTS (Mass. Gen. Laws ch. 175, §§ 108, 110(G); ch. 176A, § 8; ch. 176B, § 7; ch. 176G, § 6; ch. 176I, § 2.)

Applies to “clean claims” only; electronic claims must be paid in 45 days; written claims must be paid in 45 days.

Penalties: 1.5% per month, not to exceed 18% per year.

Other Stipulations: Applies to participating providers only; in lieu of payment, insurers can send the provider the reason for denial or list additional information needed within 45 days of receipt of claim.

Premium Delinquency Exception/Grace Period: No less than 10 days grace period. NAIC Model. § 108(3); ch. 176, § 8(b).

Fraud and Abuse Provisions Exception: Interest payments shall not apply to a claim that an insurer is investigating because of suspected fraud. Ch. 175, §§ 108(4), 110(G); ch. 176A, § 8(e); ch. 176B, § 7; ch. 176G, § 6; ch. 176, § 2(e).

Provider Timely Filing: NAIC Model. Ch. 175, § 110(G).

MICHIGAN (Mich. Comp. Laws §§ 500.2006, 1-14; 550.1403, 1-2.)

Applies to “clean claims” only; electronic claims must be paid in 45 days; written claims must be paid in 45 days.

Penalties: 12% per year.

Other Stipulations: Request information within 30 days; response by provider within 30 days of receipt of notice; pay/deny within 15 days of receipt of information; penalties calculated by number of days late times the per annum rate; civil fines of no more than \$1,000 per violation, not to exceed the aggregate of \$10,000 for multiple violations.

Provider Timely Filing: Provider shall bill a health plan within one year after the date of service. NAIC Model. § 500.2006(8)(f).

MINNESOTA (Minn. Stat. § 62Q.75.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 1.5% per month or any part of the month.

Premium Delinquency Exception/Grace Period: NAIC Model. § 62A.04 Sub 2.

Fraud and Abuse Provisions Exception: A health plan administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices. § 62Q.75(e).

Provider Timely Filing: Claims must be submitted within six months from the date of service or the date the provider was informed of the responsible health plan or TPA. § 62Q.75 subds.2(e).

Adjustments/Refunds/Recoupment: Once a clean claim has been paid, the contract must provide a 12-month deadline on all adjustments and recoupments, except for close of business, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse. § 62Q.75(e).

MISSISSIPPI (Miss. Code Ann. § 83-9-5.)

Applies to “clean claims” only; electronic claims must be paid in 25 days; written claims must be paid in 35 days. § 83-9-5(1)(h)(1).

Penalties: 1.5% per month accruing after payment was due. Amounts under \$1.00 can be credited. § 83-9-5(1)(h)(3).

Other Stipulations: Any claim resubmitted with supporting documentation or information requested by the insurer shall be paid within 20 days after receipt. The Insurance Commissioner may assess additional penalties. § 83-9-5(8)(a).

Premium Delinquency Exception/Grace Period: NAIC Model. § 83-9-5(1)(c).

Fraud and Abuse Provisions Exception: A clean claim does not include claims which are submitted fraudulently or that are based upon material misrepresentations. § 83-9-5(1)(h).

Provider Timely Filing: HMO—a clean claim does not include claims submitted by a provider more than 30 days after the date of service. NAIC Model. § 83-9-5(1)(h).

MISSOURI (Mo. Rev. Stat. §§ 376.383, .384, .426.)

Does not apply to “clean claims” only; electronic claims must be paid in 45 days. § 376.383(6).

Penalties: 1% per month; additional penalty of 1.0% of the unpaid claim balance if the claim is not paid or denied within 45 processing days. § 376.383(6).

Other Stipulations: Electronic date of receipt acknowledgment must be sent within 48 hours of receipt of an electronic claim; electronic or facsimile receipt acknowledgment must be sent within 30 processing days and include whether the claim was clean or additional information needed; pay/deny/request additional information within 45 days of receipt of claim; pay/deny claim within 10 days of receipt of additional information. The Insurance Commissioner can assess administrative penalties. § 376.383(2)-(6).

Premium Delinquency Exception/Grace Period: NAIC Model. § 376.426.

Fraud and Abuse Provisions Exception: Reasonable grounds to believe that a fraudulent claim is being made, shall notify the department of insurance of the fraudulent claim. § 376.383(8).

Provider Timely Filing: Non-participating healthcare providers to file a claim for a period of up to one year from the date of service; participating healthcare providers to file a claim for a period of up to six months from the date of service. § 376.384(2).

Adjustments/Refunds/Recoupment: Not more than 12 months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider. §§ 376.384(1)(3).

MONTANA (Mont. Code Ann. §§ 33-18-231 to -233, 33-22-150 to -151.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 33-18-232.

Penalties: 10% per annum; accrues from date claim payment was due; fines can be assess up to \$25,000, unless insurer consistently paid 90% of outstanding amounts to claimant within 20 working days and all amounts within 30 working days of receipt. § 33-18-233.

Other Stipulations: Must pay/deny within 30 days of receipt or within 60 days if information is needed; exception for suspected fraud and reported to insurance commissioner; exception to time limits if insurer provides notice of reasons for failure to pay in full. § 33-18-232.

Fraud and Abuse Provisions Exception: Exception to pay/deny time limit applies if insurer has reasonable belief fraud has been committed and possible fraud is reported to the Insurance Commissioner; time limits for claim review and reimbursement demand is not to begin until evidence of fraud is reported to the Insurance Commissioner and the Commissioner has determined that insufficient evidence of fraud exists. § 33-18-232.

Adjustments/Refunds/Recoupment: If insurer limits time for claim submission, the same time limit applies to claim review and repayment request; if no limit for claim submission, 12 months from payment to request repayment, with exceptions; if incorrect payment caused by provider error, misrepresentation, omission, or concealment, time limit cannot exceed 24 months. Collection by offset is prohibited unless authorized by provider. §§ 33-22-150 to -151.

NEBRASKA (Neb. Rev. Stat. §§ 44-710.03, 44-8002 to -8008.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 44-8004.

Penalties: 12% per annum. The Insurance Director may impose penalties in the amount of \$1,00 per violation, not to exceed an aggregate of \$30,000, or more for flagrant violations. § 44-8005.

Fraud and Abuse Provisions Exception: Exception applies for fraud. § 44-8004(3)(b).

Adjustments/Refunds/Recoupment: Insurer must notify the claimant within six months of the date of the error; the notice must clearly state the nature of the error, the overpayment amount, and the three-year limitation noted below. The exception provides that, in instances of error prompted by claimant representations or nondisclosures, the insurer must notify the claimant within 15 days after the date clear, documented evidence of discovery of the error is included in its file. An insurer may use this procedure only if the claim used to adjust the first overpayment is made no later than three years after the date of the error; the date of error is the day on which the draft for benefits is issued. § 44-8008.

NEVADA (Nev. Rev. Stat. § 683A.0879.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 683A.0879(1).

Penalties: Prime rate plus 6% if claim is not paid within 30 calendar days of being approved. Unclean claims that remain unpaid within 30 calendar days of receiving additional information shall be assessed at the prime rate plus 6% from the 31st day until the claim is paid. § 683A.0879(2).

Other Stipulations: If additional information is needed, it must be requested within 20 days of receipt of claim; pay/deny within 30 days of receipt of additional information. § 683A.0879(2).

Provider Timely Filing: NAIC Model. § 683A.0879.

NEW HAMPSHIRE (N.H. Rev. Stat. Ann. §§ 415:6-h, 415:18-m, 420:A:17-e, 420-j:8-b.)

Applies to “clean claims” only; electronic claims must be paid in 15 calendar days; written claims must be paid in 45 calendar days. § 415:6-h.

Penalties: 1.5% per month from the date payment was due; no interest is due if paid within 10 days of receiving notice from the provider that payment is overdue. § 415:6-h.

Other Stipulations: Notice must be sent to provider within 15 days of claim receipt when additional information is needed or claim is denied; providers may collect attorney fees upon judicial finding of bad faith; the Insurance Commissioner can impose fines for business practices in violation. § 415:6-h.

Fraud and Abuse Provisions Exception: No insurer shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process. § 415:6-h(VI)(c).

Provider Timely Filing: No insurer shall be in violation of this section for any claim submitted more than 90 days after the service was rendered. § 415:6-h(VI)(b).

Adjustments/Refunds/Recoupment: Within eight months from the date of payment of the challenged claim. Exceptions provide that retroactive denial is permitted beyond the 18-month period if (1) the claim was submitted fraudulently; (2) the claim payment was incorrect because the provider or insured was already paid for the services identified in the claim; (3) the services identified in the claim were not delivered by the provider; (4) the claim payment was for services covered by Titles XVIII, XIX, or XXI of the Social Security Act; (5) the claim payment is the subject of adjustment with a different insurer, administrator, or payor and such adjustment is not affected by a contractual relationship, association, or affiliation involving claims payment, processing, or pricing; or (6) the claim payment is the subject of legal action. “Retroactive denial of a previously paid claim” means any attempt by an insurer, health service corporation, or health carrier to retroactively collect payments already made to a health care provider with respect to a claim. Notices—the provider must be notified at least 15 days in advance of the imposition of any retroactive denials of previously paid claims; the provider shall then have six months from the notification date to determine whether the insured has other appropriate insurance which was in effect on the date of service. §§ 415:6-i, :18-m; 420-A:17-e; 420-j:8-b.

NEW JERSEY (N.J. Stat. Ann. §§ 17:48-8.4, 17B:27-40.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 40 calendar days. § 17:48-8.4.

Penalties: 10% per year. § 17:48-8.4.

Other Stipulations: Request information or denied claims within 30 days of receipt; pay within 30 days of information for electronic claims or 40 days of receipt of information for other claims; include 10% per year, simple interest with overdue capitation payments; up to \$10,000 civil penalties for repeated late claims payments. N.J.A.C. 11:22, 1.1 to 1.10.

Provider Timely Filing: NAIC Model. § 17B:27-40-42.

Adjustments/Refunds/Recoupment: Within 18 months after the date of the first payment on the claim is made. The exception provides that the 18-month restriction does not apply to claims that were (1) submitted fraudulently, (2) submitted by health care providers that have a pattern of inappropriate billing, or (3) subject to coordination of benefits. A payer may not seek more than one reimbursement for overpayment on a particular claim. Notices and Payer Recoupment—When a reimbursement request is submitted to the provider, the payer must provide documentation identifying the error(s) made by the payer in the processing or payment of the claim that justifies the request. § 17B:26-9.1.d(10)-(12); N.J. Admin. Code 11:22-1.6(f).

NEW MEXICO (N.M. Stat. Ann. §§ 59A-16-21.1, 59A-16C-10, 59A-22-8 to -23.)

Applies to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 45 days. § 59A-16-21.1.

Penalties: 1.5% per month; non-HMO penalty is 1.5 times the prime interest-lending rate; HMO penalty is 1.5% per month; administrative penalties up to \$5,000 per violation or \$10,000 for willful and intentional violation. § 59A-16-21.1.

Other Stipulations: Requests for additional information must be made within 30 days of receipt of electronic claims or 45 days of receipt of manual claims. § 59A-16-21.1.

Premium Delinquency Exception/Grace Period: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. NAIC Model. § 59A-22-23.

Fraud and Abuse Provisions Exception: § 59A-16C-10.

Provider Timely Filing: NAIC Model. § 59A-22-8.

NEW YORK (N.Y. Ins. Law §§ 3221, 3224-a, 3224-b.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 3224-a(a).

Penalties: 12% per annum rate accrued on the 46th day. § 3224-a(c).

Other Stipulations: Request additional information within 30 days of claim receipt; pay/deny claim within 45 days of receipt of additional information. Per six-month period, violation values are (1) less than 0.01% of \$100 per violation, (2) greater than 0.01%, but less than 0.02% of \$200 per violation, (3) greater than 0.02%, but less than 0.03% of \$500 per violation, (4) and greater than 0.03% of \$750 per violation.

Premium Delinquency Exception/Grace Period: Premiums due under the policy shall be remitted on or before the due date thereof, with such period of grace. § 3221.

Fraud and Abuse Provisions Exception: § 3224-a(a).

Provider Timely Filing: § 3221.

Adjustments/Refunds/Recoupment: For physician healthcare claims submitted for payment after January 1, 2007, insurers and HMOs must commence overpayment recovery within 24 months of the original date payment was received by a physician, except in cases involving fraud, intentional misconduct, abusive billing, or when initiated at the request of a self-funded plan or required by a state or federal government program. Notices—other than in the case of duplicate payment recovery, insurers and HMOs must give physicians 30 days notice before engaging in overpayment recovery efforts. § 3224-b.

NORTH CAROLINA (N.C. Gen. Stat. §§ 58-2-70; 58-3-100, -200, -225; 58-65-125.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 18% per year after the 30th day, and/or a civil penalty. § 58-2-70.

Other Stipulations: Pay/deny/request information within 30 days of claim receipt; pay/deny within 30 days of receipt of additional information. No violation or interest owed for failure to comply caused by the person submitting the claim or matters beyond insurer’s control.

Premium Delinquency Exception/Grace Period: An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant notice that the claim is pending based on nonpayment of fees or premiums. § 58-3-225(b).

Fraud and Abuse Provisions Exception: If the insurer has a reasonable basis to believe that the claim was submitted fraudulently. § 58-3-225(k).

Provider Timely Filing: 180 days after the date of the provision of care to the patient by the healthcare provider facility claims, within 180 days after the date of the patient’s discharge. § 58-3-225(f).

Adjustments/Refunds/Recoupment: To the extent permitted by the contract between a healthcare provider and healthcare facility, the insurer may recover overpayments made to the provider or facility by demanding refunds or by offsetting future payments. When recouping payments, insurers must give sufficient detail so that providers and facilities can identify the specific claim against which the recoupment is being made and the reason for the recoupment. The period for which such recoveries may be made may be specified in the parties’ contract. §§ 58-3-200(c), 58-3-225(h).

NORTH DAKOTA (N.D. Cent. Code § 26.1-36-4, -5, -37.1.)

Does not apply to “clean claims” only; electronic claims must be paid in 15 business days; written claims must be paid in 15 business days. § 26.1-36-37.1.

Other Stipulations: Pay/deny/request additional information within 15 days of claim receipt; pay/deny within 15 days of receipt of additional information. § 26.1-36-37.1.

Premium Delinquency Exception/Grace Period: NAIC Model. § 26.1-36-4(e).

Provider Timely Filing: NAIC Model. §§ 26.1-36-4(g), 26.1-36-5(8).

OHIO (Ohio Rev. Code Ann. §§ 3901.38, .381, .384, .388, .389, .3812; 3923.04)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 3901.381

Penalties: 18% simple interest per year; interest must be paid directly to the provider when the claim is paid and may not be used to offset other payments. § 3901.389(C).

Other Stipulations: Pay/deny/request additional information within 30 days of claim receipt; pay/deny claim no later than 45 days after receipt of claim when supporting documentation is needed; patterns of violations may result in fines of up to \$100,000 for the first offense, up to \$150,000 for the second offense within four years, and up to \$300,000 for the third offense within seven years. § 3901.3812.

Premium Delinquency Exception/Grace Period: § 3923.04(C).

Provider Timely Filing: NAIC Model. Claims submitted later than one year from the date of service must be paid or denied within 90 days of receipt. Claims may be denied for processing if submitted later than 45 days after receiving notice from a different payer or state or federal program that it is not responsible for the claim, or the provider does not submit notice of denial from the other payer/program. §§ 3901.384, 3923.04(E).

Adjustments/Refunds/Recoupment: Within two years after payment was made; written notice required. An exception is fraud. § 3901.388.

OKLAHOMA (Okla. Stat. tit. 36, §§ 1219, 4405)

Does not apply to “clean claims” only; electronic claims must be paid in 45 calendar days; written claims must be paid in 45 calendar days. § 1219(A).

Penalties: 10% per year. § 1219(F).

Other Stipulations: Insurers must notify the insured or provider in writing within 30 calendar days of receipt of claim of defects or improprieties and information needed to correct defects. § 1219(A), (C), (D).

Provider Timely Filing: § 4405(A)(7), (G).

OREGON (Or. Rev. Stat. §§ 743.866, 743.868.)

Applies to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days.

Penalties: 12% per annum; interest of \$2.00 or less need not be paid.

Other Stipulations: Pay/deny request additional information within 30 days of claim receipt; pay/deny within 30 days of receipt of additional information; interest amounts less than \$2.00 per claim is not required to be paid.

Premium Delinquency Exception/Grace Period: NAIC Model. § 743.417.

Provider Timely Filing: NAIC Model. Proof of loss must be filed within 90 days after the date of loss. § 743.429.

PENNSYLVANIA (13 Pa. Cons. Stat. tit. 40 § 991.2166.)

Does not apply to “clean claims” only; electronic claims must be paid in 45 days; written claims must be paid in 45 days.

Penalties: 10% per year.

Other Stipulations: When Capital Blue Cross, Highmark and Blue Cross of Northeastern PA are Host Plans and does not apply with Independence Blue Cross.

Premium Delinquency Exception/Grace Period: NAIC Model. 40 P.S. § 753(3).

Provider Timely Filing: NAIC Model. 40 P.S. § 753.

RHODE ISLAND (2006 R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47, 27-41-64.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 40 calendar days.

Penalties: 12% per year.

Other Stipulations: Request of additional information must be within 30 days of claim receipt; pay/deny within 30 days electronic claim or 40 days paper claim of receipt of additional information.

Premium Delinquency Exception/Grace Period: NAIC Model. § 27-18-3(b).

Fraud and Abuse Provisions Exception: No healthcare plan shall be in violation of this section while the claim is pending due to a fraud. §§ 27-18-61(e)(3), 27-19-52(e)(3), 27-20-47(e)(3), 27-41-64(e)(3).

Provider Timely Filing: 90 days after the service is rendered. §§ 27-18-61(e)(2), 27-19-52(e)(2), 27-20-47(e)(2), 27-41-64(e)(2).

Adjustments/Refunds/Recoupment: Recoupment or set-off of funds previously paid to the provider with respect to such claims must be completed no later than two years after the completed claim was submitted. Exceptions include (1) fraud; (2) a pattern of inappropriate billing; (3) coordination of benefits; or (4) any federal laws or regulations permitting claims review beyond the two years. §§ 27-18-64, 27-19-56, 27-20-51, 27-41-69.

SOUTH CAROLINA (S.C. Code Ann. §§ 34-31-20; 38-59-230, -250, -270; 38-71-735.)

Applies to “clean claims” only; electronic claims must be paid in 20 days; written claims must be paid in 40 days.

Penalties: 8.75% interest per annum.

Other Stipulations: Interest need not be paid when a duplicate claim is submitted within 20 days electronic claim or 40 days paper claim of the original claim submission; interest need not be paid when a participating provider balance bills a member in violation of the provider agreement; interest need not be paid when payment is made to a plan member.

Premium Delinquency Exception/Grace Period: NAIC Model. § 38-71-735(a).

Provider Timely Filing: NAIC Model. § 38-71-735(g).

SOUTH DAKOTA (S.D. Codified Laws §§ 58-12-19 to -21, 58-17-21 to -24.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 58-12-20.

Other Stipulations: Request additional information within 30 days of claim receipt; requested information must be sent to insurer within 30 days of receipt of request. § 58-12-20.

Premium Delinquency Exception/Grace Period: The term “clean claim” does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. §§ 58-12-19 to -21.

Fraud and Abuse Provisions Exception: The term “clean claim” does not include a claim for which fraud is suspected. §§ 58-12-19 to -21.

Provider Timely Filing: NAIC Model. Proof of loss must be submitted within 90 days after the date of loss. Failure to do so does not invalidate or reduce any claim as long as it is furnished as soon as reasonably possible and not later than one year from the time proof is otherwise required. §§ 58-17-21, -24.

TENNESSEE (Tenn. Code Ann. §§ 56-7-109, -110.)

Applies to “clean claims” only; electronic claims must be paid in 21 calendar days; written claims must be paid in 30 calendar days. § 56-7-109(b)(1).

Penalties: 1% per month. § 56-7-109(b)(4).

Other Stipulations: Request information within 21 days electronic claim or 30 days paper claim of claim receipt; \$10,000 penalty if 95% of unpaid clean provider claims during the year; penalty of not less than \$10,000 nor more than \$100,000 for 85% of unpaid provider clean claims; penalty of not less than \$100,000 nor more than \$200,000 for less than 60% of unpaid provider clean claims. § 56-7-109(c)(2).

Fraud and Abuse Provisions Exception: Except in cases of provider fraud, a health insurer may only retroactively deny reimbursements to the provider during the 18-month period after the date that the health insurer paid the provider submitted claim. § 56-7-110(c).

Provider Timely Filing: A clean claim does not include any claim submitted more than 90 days after the date of service. § 56-7-109(c).

Adjustments/Refunds/Recoupment: A health insurer shall not be required to correct a payment error if the provider’s request for a payment correction is filed more than 18 months after the date of payment. § 56-7-110.

TEXAS (See main paper.)

UTAH (Utah Code Ann. §§ 31A-22-614, 31A-26-301.6.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. § 31A-26-301.6.

Penalties: Calculate penalty by multiplying the total claim amount by total number of days late by 0.1%, for the first 90 days late. For more than 90 days late, calculate penalty by adding the 90-day late fee and the sum of the total claim amount, number of days late beyond the initial 90 days and the rate of interest under § 15-1. Also applies to providers who fail to provide information on a claim. § 31A-26-301.6.

Other Stipulations: Request additional information within 30 days of claim receipt; additional information must be provided to insurer within 30 days of receipt of request, unless a 30 day extension is requested; pay/deny claim within 20 days of receipt of additional information. § 31A-26-301.6.

Provider Timely Filing: § 31A-22-614.

Adjustments/Refunds/Recoupment: An insurer may recover any amount improperly paid (1) in accordance with the Utah Fraudulent Insurance Act or another state or federal law; (2) within 36 months for a coordination of benefits error; or (3) within 18 months for any other reason. § 31A-26-301.6(15).

VERMONT (Vt. Stat. Ann. tit. 18, § 9418.)

Does not apply to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days.

Penalties: 12% per year.

Other Stipulations: Notice of receipt of electronic claims must be sent to providers within 24 hours of the next business day of receipt; request additional information within 30 days of claim receipt; pay/deny claim within 30 days of receipt of additional information.

Premium Delinquency Exception/Grace Period: 8 V.S.A. § 4514(7).

Fraud and Abuse Provisions Exception: 8 V.S.A. § 4065(2).

Provider Timely Filing: Tit. 8, part 3, ch. 107, subch. 1, § 4065(5).

Adjustments/Refunds/Recoupment: Retroactive denials are prohibited beyond 12 months of claims payment, except for close of business, fraud, other legal actions for recovery, or duplicate payments.

VIRGINIA (Va. Code Ann. §§ 38.2-3407.15, -3527.)

Does not apply to “clean claims” only; electronic claims must be paid in 40 days; written claims must be paid in 40 days. § 38.2-3407.15.

Penalties: 6% per year; the penalty is the rate established under §§ 38.2-3407.1 or 38.2-4306.1, the rate in the provider contract, or 6% per year after the 15th day on non-HMO-insured business. §§ 38.2-3407.1, -4306.1.

Other Stipulations: Request additional information within 30 days of claim receipt; pay/deny claim within 40 days of receipt of additional information. § 38.2-3407.15.

Premium Delinquency Exception/Grace Period: NAIC Model. § 38.2-3527.

Fraud and Abuse Provisions Exception: Exceptions apply when the claim was submitted fraudulently. § 38.2-3407.15.

Provider Timely Filing: Notice of claim. NAIC Model. § 38.2-3534.

Adjustments/Refunds/Recoupment: No retroactive denials of previously paid claim unless the carrier has provided the reason and (1) the original claim was submitted fraudulently, (2) the provider was already paid for the services or the services were not delivered, or (3) the time which has elapsed since the payment does not exceed 12 months. § 38.2-3407.15(B)(6), (7).

WASHINGTON (Wash. Rev. Code §§ 48.31B.035, 51.36.085, 284.43.321.)

Applies to “clean claims” only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. § 48.31B.035.

Penalties: 1% per month on any clean claim unpaid and un-denied after 60 days. § 51.36.085.

Other Stipulations: Pay/deny within 60 days of receipt of non-clean claims. § 51.36.085.

Premium Delinquency Exception/Grace Period: NAIC Model. § 284.44.040(8).

Fraud and Abuse Provisions Exception: These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities, or covered persons. § 284.43.321(6).

Adjustments/Refunds/Recoupment: Refunds must be requested within 24 months from payment date, except for fraud; refunds for close of business must be requested within 36 months; providers may not request additional payments after 24 months from claim denial or 36 months from denial for close of business. §§ 48.43.600, .605.

WEST VIRGINIA (W. Va. Code §§ 33-45-2.)

Applies to “clean claims” only; electronic claims must be paid in 30 calendar days; written claims must be paid in 40 calendar days. § 33-45-2(a)(1).

Penalties: 10% per year. § 33-45-1(a)(4).

Other Stipulations: Request additional information within 30 days of receipt; second request for information within 15 days of receipt of information from first request; pay/deny within 30 days of receipt of requested information. Exceptions include when another payor is responsible, coordinating benefits, duplicate claim payment, fraud, or material misrepresentation. § 33-45-1(a)(3).

Fraud and Abuse Provisions Exception: Fraud and abuse provisions exception applies. § 33-45-2(a)(6), (7).

Adjustments/Refunds/Recoupment: Retroactive denial for duplicate claim payment or services not delivered by the provider, the provider was not entitled to reimbursement, the service provider was not covered by the health benefit plan, or the insured was not eligible for reimbursement; one-year time limit for retroactive denials, except for fraud and material misrepresentation. §§ 33-45-1(8), 33-45-2(a)(7).

WISCONSIN (Wis. Stat. §§ 628.46, 631.81.)

Applies to “clean claims” only; electronic claims must be paid in 30 days. § 628.46.

Penalties: 12% per year. § 628.46.

Provider Timely Filing: Proof of loss must be filed within one year after it was required under the policy. Failure to provide proof of loss does not reduce or invalidate a claim. §§ 628.46, 631.81.

WYOMING (Wyo. Stat. Ann. § 26-15-124.)

Does not apply to “clean claims” only; electronic claims must be paid in 45 days; written claims must be paid in 45 days. § 26-15-124(a).

Penalties: 10% per year. § 26-15-124(c).