A SURVEY OF STATE PROMPT PAY LAWS, PART I

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Many states have laws or regulations in place that require health insurers in the state to reimburse claims within a certain timeframe or face penalties, oftentimes in the form of interest applied to the amount of the claim. Such laws or regulations are typically called “Prompt Pay” laws or “Clean Claim.” While each state or, sometimes, insurer, defines the requirements for a claim to be a “clean claim,” generally, a “clean claim” is a claim that has all of the information an insurer needs to either pay or deny the claim.

A “non-clean claim” is a claim that requires additional information or documentation to make it clean. Each state sets forth the timeframes in which insurers have to reimburse a clean claim. Absent certain exceptions (e.g., instances of suspected fraudulent activity, contractual provisions setting forth alternative timeframes, etc.), failure to adhere to the timeframes results in penalties oftentimes in the form of interest applied to the amount of the claim and some states impose administrative penalties upon insurers that regularly fail to adjudicate claims in a timely fashion.

The purpose of this two-part survey is to outline and list the key elements of states’ prompt pay laws as they pertain to anesthesiologists, focusing on the relevant timeframes in place for insurance companies as well as the potential penalties for failure to comply. Of course, every instance of reimbursement is unique and should be addressed based on its distinct facts and circumstances.

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| Alabama | Code of Ala. §27-1-17 | • Insurers  
• Health service corporations  
• Health benefit plans  
• HMOs | Upon receipt of a clean claim:  
• Written: 45 calendar days  
• Electronic: 30 calendar days  
Upon receipt of amended claims/supplemental information: 21 calendar days | Upon receipt of a claim:  
• Written: 45 calendar days  
• Electronic: 30 calendar days | • 1.5 % per month, prorated daily  
• Willful violations could result in fines of up to $1000 per claim |
| Alaska | Alaska Stat. §21.36.495 | • Insurance companies  
• Hospital or medical service corporations  
• Fraternal benefit societies  
• HMOs  
• Multiple employer welfare arrangements  
• Church plans  
• Certain governmental plans | Upon receipt of a clean claim: 30 days  
Upon receipt of amended claims/supplemental information: 15 days | Upon receipt of a claim: 15 calendar days | 15% annually, but is not required if the interest is $1 or less |
| Arizona | ARS §20-3102 | • Disability insurers  
• Group disability insurers  
• Blanket disability insurers  
• Healthcare services organizations  
• Prepaid dental plan organizations  
• Hospital service corporations  
• Medical service corporations  
• Dental service corporations  
• Optometric service corporations  
• Hospital, medical dental and optometric service corporations | Upon receipt of a clean claim:  
• 30 days to adjudicate  
• 30 days to pay  
Upon receipt of amended claims/supplemental information: 30 days to adjudicate and pay | Upon receipt of a claim: 30 days | 10% per annum |
| Arizona | ARS §20-462 | Enrollees who have paid providers directly for covered out-of-network services | Upon receipt of an acceptable proof of loss by the insurer containing all the information necessary for claim adjudication: 30 days | N/A | 10% per annum |

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| Arkansas | ACA §20:66-215; 054 00 CARR 043 §12-13. | • HMOs  
• Hospital medical service corporation  
• Disability insurance companies  
• Self-insured governmental or church plan  
• Third party administrators that administer or adjust disability benefits for a disability insurer | Upon receipt of a clean claim:  
• Written: 45 days  
• Electronic: 30 days  
Upon receipt of amended claims/ supplemental information: 30 days | Upon receipt of a claim: 30 days | 12% per annum |
| California | Cal. Ins. Code §10123.13 | Every insurer issuing group or individual policies of health insurance covering hospital, medical or surgical expenses, including those of telemedicine services covered by the insurer | Upon receipt of a claim: 30 working days  
Upon receipt of additional information: 30 working days | Upon receipt of a claim: 30 working days | 10% per annum |
| California | Cal. Health & Saf Code §1371.35  
28 CCR 1300.71 | Health care service plans | Upon receipt of a complete claim, or portion thereof:  
• General: 30 working days  
• HMOs: 45 working days | Upon receipt of a complete claim:  
• General: 30 working days  
• HMOs: 45 working days | The greater of $15 per year or interest at a rate of 15% per annum |
| Colorado | CRS §10-16-106.5 | • Any entity providing health coverage  
• Franchise insurance plan  
• Fraternal benefit society  
• HMO  
• Nonprofit hospital and health service corporation  
• Sickness and accident insurance company | Upon receipt of a clean claim:  
• Electronic: 30 calendar days  
• Submitted by any other means: 45 calendar days  
Claims requiring amendments/ supplemental information: 90 days from the date the claim was received by the insurer | Upon receipt of claim: 30 calendar days | Clean claims: 10% per annum  
Amended/supplemental claims: 20% of the total amount of the claim |
Conn. Gen. Stat. §38a-815 | • Insurers  
• Other entities responsible for providing payment to a healthcare provider pursuant to an insurance policy | Upon receipt of a claim that is not deficient: 45 days  
Upon receipt of the deficient information: 30 days from the date the information was received by the insurer | Upon receipt of claim: 30 days | 15% per annum |
| Delaware | CDR 18-1300-1310 | Any entity that provides health insurance in Delaware, includes:  
• Health insurance company  
• Health service corporation  
• HMO  
• Entity providing a plan of health insurance or health benefits  
• Third party administrator  
• Entity that adjust, administers or settles claims in connection with health benefit plans | Upon receipt of a clean claim: 30 days  
Upon receipt of additional information: 15 days | Upon receipt of claim: 30 days | The maximum rate allowable to lenders under Delaware law |
| Delaware | 19 Del. C. §2322F | Employer or insurance carrier. | Upon receipt of a clean claim: 30 days | Non-preauthorized claims must be referred to the utilization review within 15 days | 1% per month for non-preauthorized claims  
Violation of this law could result between a $1000-$5000 fine |
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| District of Columbia | DC Code $31-3132 | Any person that provides one or more health benefit plans or insurance in DC, including a/an:  
- Insurer  
- Hospital and medical services corporation  
- Fraternal benefits society  
- HMO  
- Multiple employer welfare arrangement  
- Any other person providing a plan of health insurance subject to the authority of the Insurance Commissioner | Upon receipt of a clean claim: 30 days  
Upon receipt of additional information: 30 days | Upon receipt of claim: 30 days | Days 31-60 = 1.5% interest  
Days 61-120 = 2% interest  
Days beyond 120 = 2.5% interest |
| Florida       | Fla. Stat. $627.613  
Fla. Stat. $627.622 | Out-of-State Providers and Policyholders  
Types of Insurance:  
- Hospital and medical expense incurred policy  
- Minimum premium plan  
- Stop-loss coverage  
- HMO  
- Prepaid health clinic contract  
- Multiple-employer welfare arrangement contract  
- Fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract | Upon receipt of a claim: 45 days  
Upon receipt of additional information: 60 days  
All claims must be paid or denied within 120 days of receipt of the claim | Upon receipt of a claim: 45 days | 10% per year |
|               | Fla. Stat. $627.613  
Fla. Stat. $641.3155  
Fla. Stat. $627.622 | In State Providers and Policyholders  
Types of Insurance:  
- Hospital and medical expense incurred policy  
- Minimum premium plan  
- Stop-loss coverage  
- HMO  
- Prepaid health clinic contract  
- Multiple-employer welfare arrangement contract  
- Fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract | Upon receipt of a claim:  
Electronic: 20 days  
Non-Electronic: 40 days | Upon receipt of a claim:  
Electronic: 20 days  
Non-Electronic: 40 days | 12% per year |
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| Georgia   | OCGA §33-25-59.14                       | • Accident and sickness insurer                                                                                  | Upon receipt of a clean claim:  
  • Electronic: 15 working days  
  • Paper: 30 calendar days  
Upon receipt of additional information:  
  • Electronic: 15 working days  
  • Paper: 30 calendar days | • Electronic: 15 working days  
• Paper: 30 calendar days | 12% per annum |
| Hawaii    | HRS §431:13-108                        | • Accident and health or sickness insurance providers  
• Mutual benefit societies  
• Dental service corporations  
• HMOs | Upon receipt of a clean claim:  
  • Electronic: 15 calendar days  
  • Paper: 30 calendar days  
Upon receipt of additional information:  
  • Electronic: 15 calendar days  
  • Paper: 30 calendar days | Upon receipt of a claim:  
  • Electronic: 7 calendar days  
  • Paper: 15 calendar days | 15% per annum |
| Idaho     | Idaho Code §41-5602                     | • An insurer that sells hospital, medical, long-term care, or vision insurance policies or certificates  
• Managed care organizations  
• Third party administrators | If the claim is submitted within 30 days of the date of service:  
  30 days  
If the claim is submitted within 45 days of the date of service:  
  45 days  
If the provider or facility submits supplemental information within 30 days of receipt of the notice:  
  30 days | Upon receipt of a claim:  
  • Electronic: 30 days  
  • Paper: 45 days | 12% per year |
| Illinois  | 215 ILCS 5/368a                        | • HMOs  
• Managed care plans  
• Healthcare plans  
• Preferred provider organizations  
• Third party administrators  
• Independent practice associations  
• Physician-hospital organizations | Periodic Payments: within 60 days after the healthcare professional or healthcare facility has been selected or the effective date of the selection, whichever is later, and according to the periodic monthly cycle thereafter  
Non-Periodic Payments: 30 days after receipt of written proof of loss | Upon receipt of a proof of loss: $30 days | 9% per year |
| Indiana   | Ind. Code Ann. §27-8-5.7-5              | Insurance company that issues accident and sickness insurance policies, including a preferred provider plan, and an insurance administrator that collects or charges premiums and adjusts or settles claims | Upon receipt of, or establishing, a clean claim:  
  • Electronic: 30 days  
  • Paper: 45 days | Upon receipt of a clean claim:  
  • Electronic: 30 days  
  • Paper: 45 days | Statutory interest rate pursuant to Ind. Code 12-15-21-3(7)(A) (formulaic) |
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| Iowa      | Iowa Code 5507B.4A 191 IAC §15.32         | • Insurers providing accident and sickness insurance  
• HMOs  
• Organized delivery systems  
• Any other entity providing health insurance or health benefits | Upon receipt of a clean claim or properly completed billing instrument: 30 days | N/A                               | 10% per annum   |
| Kansas    | KSA §40-2441                               | • Any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident, or both  
• Any hospital, dental or medical expense policy  
• Health, hospital, medical service corporation contract issued by a stock or mutual company or association  
• HMO or any other insurer  
• Third party administrator  
• Any other entity that pays claims pursuant to a policy of accident and sickness insurance | Upon receipt of a clean claim: 30 days  
Upon receipt of supplemental information: 15 days | N/A                               | 1% per month    |
| Kentucky  | KRS §304.17A-702 806 KAR §17:310           | • Any insurance company  
• HMO  
• Self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA  
• Provider-sponsored integrated health delivery network  
• Self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky | Upon receipt of a clean claim: 30 days  
Upon receipt of a clean claim involving organ transplant: 60 days | Upon receipt of a claim:  
• Electronic: 48 hours  
• Nonelectronic: 20 calendar days | • For claims 1-30 days overdue: 12% per annum  
• For claims 31-60 days overdue: 18% per annum  
• For claims over 60 days overdue: 21% per annum |
| Louisiana | La. R.S. §22:1831 et seq. LAC §37.XI.6001 et seq. | Any entity that offers health insurance coverage through a policy, contract or certificate of insurance, including HMOs | Upon receipt of a clean claim:  
• Non-electronic, participating provider, claim submitted within 45 days of the date of service or date of discharge: 45 days  
• Non-electronic, participating provider, claim submitted more than 45 days of the date of service or date of discharge: 60 days  
• Non-electronic, non-participating provider: 45 days  
• Electronic: 25 days | Upon receipt of an electronic claim: 5 days | 12% per annum   |

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<tr>
<td>Maine</td>
<td>45-A MRS $2436</td>
<td>Claims submitted under a policy or certificate of insurance delivered or issued for delivery in Maine</td>
<td>Upon receipt of an undisputed claim: 30 days&lt;br&gt;Upon receipt of supplemental information in connection with a disputed claim: 30 days</td>
<td>Upon receipt of a claim: 30 days</td>
<td>1.5% per month</td>
</tr>
<tr>
<td>Maryland</td>
<td>Md. Ins. Code §15-1005</td>
<td>• Insurers&lt;br&gt;• Nonprofit health service plans&lt;br&gt;• HMOs</td>
<td>Upon receipt of a clean claim or any undisputed portion of a claim: 30 days&lt;br&gt;Upon receipt of supplemental information in connection with a disputed claim: 30 days</td>
<td>Upon receipt of a claim: 30 days</td>
<td>• Days 31-60: 1.5%&lt;br&gt;• Days 61-120: 2%&lt;br&gt;• Days 121 and beyond: 2.5%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>ALM GL ch. 176G, §6</td>
<td>HMOs</td>
<td>Upon receipt of a claim: 45 days</td>
<td>Upon receipt of a claim: 45 days</td>
<td>1.5% per month, not to exceed 18% per year</td>
</tr>
<tr>
<td>Michigan</td>
<td>MCL 5500.2006</td>
<td>• An insurer providing benefits under an expense-incurred hospital, medical, surgical, vision, or dental policy or certificate, including any policy or certificate that provides coverage for specific diseases or accidents only, or any hospital indemnity, Medicare supplement, long-term care, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement.&lt;br&gt;• A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits.&lt;br&gt;• A health maintenance organization licensed or issued a certificate of authority in this state.&lt;br&gt;• A health care corporation for benefits provided under a certificate issued under the nonprofit health care corporation reform act, but not to payments made pursuant to an administrative services only or cost-plus arrangement.</td>
<td>Upon receipt of a clean claim: 45 days&lt;br&gt;Upon receipt of supplemental information in connection with a defective claim: 45 days minus the number of days until the healthcare provider received notice of the claim's defects</td>
<td>Upon receipt of a claim: 45 days</td>
<td>12% per annum</td>
</tr>
<tr>
<td>STATE</td>
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<tr>
<td>Minnesota</td>
<td>Minn. Stat. §620.75</td>
<td>HMOs, Community integrated service networks, Preferred provider organizations, Licensed insurance companies, Nonprofit health service corporations, Fraternal benefit plans, Any other entity that establishes, operates or maintains a health benefit plan or network of healthcare providers where the providers have entered into a contract with the entity to provide healthcare services</td>
<td>Upon receipt of a clean claim: 30 calendar days</td>
<td>N/A</td>
<td>1.5% per month</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Miss. Code. Ann. §83-9-5</td>
<td>Accident and health insurers</td>
<td>Upon receipt of a clean claim:</td>
<td>Upon receipt of a clean claim:</td>
<td>1.5% per month</td>
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<td>• Electronic: 25 days</td>
<td>• Electronic: 25 days</td>
<td>Paper: 35 days</td>
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<td>• Paper: 35 days</td>
<td>• Paper: 35 days</td>
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<td>Upon receipt of supplemental information: 20 days</td>
<td>Upon receipt of a clean claim: 30 days</td>
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<tr>
<td>Missouri</td>
<td>R.S. Mo. §376.383</td>
<td>Any entity subject to the Missouri insurance laws, Self-insured plans allowed by federal law, Third party contractors</td>
<td>Upon receipt of a clean claim: 30 processing days</td>
<td>Upon receipt of a claim: 30 processing days</td>
<td>1% interest per month</td>
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<td></td>
<td>Upon receipt of supplemental information pursuant to the first request: 10 processing days</td>
<td>Upon receipt of supplemental information pursuant to the first request: 10 processing days</td>
<td>Upon receipt of supplemental information pursuant to the first request: 10 processing days</td>
<td>1% penalty per day</td>
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</tbody>
</table>

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