## FACT SHEET

**Colorado Revised Statute: 10-16-106.5- Prompt Payment of claims**

**Following are the important elements of this law:**

- All carriers must accept the uniform health care claim forms. See CRS 10-16-106.3 (Uniform claims-billing codes-electronic claim forms) and Regulation 4-2-24 (Concerning Clean Claim Requirements for Health Carriers) Fact Sheet.
- All carriers must accept claims in electronic form; but shall not prohibit submission in hard copy form. See CRS 10-16-106.3 (Uniform claims-billing codes-electronic claim forms) and Regulation 4-2-24 (Concerning Clean Claim Requirements for Health Carriers) Fact Sheet.
- The Insurance Commissioner shall adopt a uniform list of required elements to be used on the uniform claim forms in order for a claim to be considered a clean claim. See CRS 10-16-106.3 (Uniform claims-billing codes-electronic claim forms) and Regulation 4-2-24 (Concerning Clean Claim Requirements for Health Carriers) Fact Sheet.
- A carrier shall make a mechanism available to providers that shall enable a provider to confirm the receipt of a claim that is filed with the carrier in a manner other than electronically. Within ten business days after the submission of the claim as determined by the provider, the carrier shall list such claim on the notification mechanism as received. The claim shall be deemed received on the date it is listed on the notification mechanism by the carrier. If a claim is not listed on the notification mechanism, the provider may contact the carrier for the purposes of resubmission of the claim.
- Carriers shall establish a separate facsimile process to receive resubmission of paper claims; the receipt date for the claim will be the date of the facsimile transmission acknowledgment.
- Electronic claims are presumed to be received on the date of the electronic verification of receipt by the carrier or the carrier's clearinghouse. The carrier or the carrier's clearinghouse shall provide a confirmation within one business day after submission by the provider.
- A clean claim must be *paid, denied or settled within 30 days after receipt by the carrier if submitted electronically and 45 days if submitted by other means* (hard-copy)…
- A claim requiring additional information shall not be considered a clean claim. See CRS 10-16-106.3 (Uniform claims-billing codes-electronic claim forms) and Regulation 4-2-24 (Concerning Clean Claim Requirements for Health Carriers) Fact Sheet.
- If additional information is required to process the claim, the carrier must provide you (or the patient) with a complete written explanation of the information required including any additional medical or other information related to the claim within 30 days after receipt of the claim.

- The carrier may deny the claim if you do not provide the additional information within 30 days of receipt of the request. The claim may be appealed or resubmitted for consideration with the additional information.
- Once the carrier receives the additional information necessary to process a "dirty" claim, it must be paid, denied or settled within 90 calendar days from original receipt date.
- The carrier must settle all claims, other than clean claims, within 90 days after receipt.
- A carrier that does not settle a clean claim within 30/45 days; contact you for additional information within 30 days; or settle any other claim within 90 days shall pay the physician (or patient if you are not participating with the plan) *interest at the rate of 10% annually on the total allowed amount, accruing from the date the payment was due…*
- A carrier that fails to pay, deny or settle a claim within 90 days after receipt shall pay an additional penalty of 10% of the total amount allowed.
- If the carrier does not pay the penalties with the claim, they may aggregate the penalties for the provider and pay on a quarterly basis or when the amount owed exceeds ten dollars.
- If a carrier delegates the claims processing function to another entity, such as a physician organization (e.g., PMG, POD), the delegation agreement shall require that the entity comply with these same timely processing standards.
- The law applies to fully insured health insurance plans in the state of Colorado. It does not apply to self-insured health plans (such as unions and large/multi-state employer groups). These plans are subject to federal ERISA (Employee Retirement Income Security Act) laws. (Note: There may not be anything on the patient's ID card that identifies it as an ERISA plan. In this case the only way to determine this is to contact the health plan and ask.)
- The law does not apply to Auto No-Fault, Worker's Compensation, Medicaid and Medicare; they are already subject to other processing requirements.

**In summary - How to make the Prompt Payment law work for you:**

- *Submit a clean claim*.
- *Be sure the claim is one that falls under the state law*.
- *Respond promptly to a request for additional information from the insurance carrier*.
- *Monitor your claims*. Set up a system in your office to track the timeliness of the insurance carrier's processing. Utilize the claims status mechanisms established by each carrier to verify receipt of your claim, and if necessary resubmit the claim via the facsimile process.
- *Continue to let us know if there are carriers that are not paying timely.*

If you have any questions, you can contact Marilyn Rissmiller at CMS on (720) 859-1001 or 1-800-654-5653, ext. 6328.