Dental Insurance Reform
Retroactive Denials

Retroactive Denial of Coverage

Dental plans have the ability to review claims *after* payment has been delivered to dentists and request claim payment refunds under certain circumstances. The laws below restrict the timeframe in which insurers are allowed to request such a refund. For more information on dental insurance issues, visit ADA.org/dentalinsurance.

2021 STATE LEGISLATION – TIME LIMITS ON INSURER TO RECOVER OVERPAYMENT

The information in this table is current as of August 2021. Click on a state to go to its state law site, which is owned and updated by each state.

STATES	TIME LIMIT	STATUTE (*)
ALABAMA 27-1-17(E)-(G) *Health and accident insurance; time for payment of claims*	• Lesser of **12 months,** or expiration of same time provider has to submit claim • **18 months,** coordination of benefits	• Prohibits retroactive denial after one year from the date that the claim was paid or after the expiration of the same period of time that the health care provider is required to submit claims whichever date occurs first. • Prohibits retroactive denial after 18 months when the reason for refund request is related to coordination of benefits. • Provider has six months from the date that notice is received to file a revised claim or a request for reconsideration with additional medical records or information.
ARIZONA A.R.S. § 20-3102 (I) *Timely payment of health care providers' claims; grievances*	• **12 months**	• Prohibits insurers from adjusting or requesting adjustment of the payment or denial of a claim more than one year after payment or denial.
ARKANSAS 23-63-1802. *Time for recoupment*	• **18 months**	• Allows recoupment from a provider only during the 18-month period after the date that the health care insurer paid the claim.

 Updated: 9/2/2021

Dental Insurance Reform
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COLORADO 10-16-704(4.5) *Network adequacy – rules – legislative declaration – definitions*	• **12 months**	• Adjustments to claims must be made within 12 months after the date of the original explanation of benefits. • For non-par dentists, adjustments must be made within 12 months after the date of the original explanation of benefits. • Adjustments to claims related to coordination of benefits with federally funded programs (i.e. Medicare and Medicaid) must be made within 36 months after the date of service. • A carrier cannot retroactively adjust a claim based on eligibility if the provider received verification of eligibility within two business days prior to the delivery of services, unless the policyholder notified the carrier of an individual's ineligibility in compliance with statute relevant to proper termination of enrollee coverage. 10-16-103.5
FLORIDA 627.6131(6)(A)1 *Payment of claims*	• **30 months**	• All claims for overpayment must be submitted to a provider within 30 months after the health insurer's payment of the claim. • Refund is considered made on the date the payment was mailed or electronically transferred. Overdue payment of a claim has a 12% per year penalty.
HAWAII § 431:13-108. *Reimbursement for accident and health or sickness insurance benefits*	• **18 months**	• Prohibits recoupment or offset efforts more than 18 months after claim payment. • Time limit does not apply to recoupment for: self-insured employer groups; for services rendered to individuals associated with a health care entity through a national participating provider network; or for claims for Medicaid, Medicare, Medigap, or other federally financed plan. • Flexibility on time limits are established for resolving claims that involve coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability beyond the 18-month time limit. • In cases of fraud or material misrepresentation, prohibits recoupment efforts more than 72 months after the claim payment was received by the health care provider.

 Updated: 9/2/2021

Dental Insurance Reform
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STATES	TIME LIMIT	STATUTE (*)
ILLINOIS 215 ILCS 5/368D(C) *Recoupments*	• **18 months**	• Prohibits recoupments 18 months or more after the original payment is made.
INDIANA 27-8-5.7-10. *Repayment or correction of error on overpayment or underpayment of provider claim – limitations* IC 27-13-36.2-9 *Claim overpayment adjustment*	• **2 years**	• An insurer may not, more than two years after the date on which an overpayment on a provider claim was made to the provider by the insurer: (1) Request that the provider repay the overpayment; or (2) Adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.
KENTUCKY 304.17A-708(3)(A) *Resolution of payment errors – retroactive denial of claims – conditions*	• **24 months**	• Insurers may retroactively deny reimbursement to a provider only during the 24-month period after the date that the insurer paid the claim submitted by the provider.
LOUISIANA § 42:859 A(2) *Refund of expenditures ineligible for reimbursement*	• **18 months**	• No refund shall be required from a plan member or health care provider on a paid claim determined by audit or review to be ineligible if a period of more than 18 months has elapsed since the date of payment of such claim.
MAINE 24-A M.R.S. § 4303 (10) *Plan requirements*	• **12 months**	• Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless: (A) The carrier has provided the reason for the retrospective denial in writing to the provider; and (B) The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. • The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the reasons specified in the law.

 Updated: 9/2/2021

Dental Insurance Reform
Retroactive Denials

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MARYLAND § 15-1008 (C) (1) *Retroactive denial of reimbursement*	• **6 months** • **18 months** (for unique transactions)	• A carrier may only retroactively deny reimbursement during the six-month period after the date that the carrier paid the health care provider. • The time extends to 18 months for coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program.
MISSISSIPPI § 83-41-219 *Reciprocal time limitations on health insurance claim filing and claim audits; applicability*	• **Reciprocal recoupment limitation –** Same time limit for provider to submit claim, or **12 months**	• The law limits the window of time insurers have to request recoupment of an invalid claim or overpayment to the same time limit insurers give to providers to submit a claim. • If an insurer *does not* limit the time that providers must submit a claim, then insurers are limited to 12 months where they are allowed to request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim.
MISSOURI § 376.384 1(3) *Reimbursement of claims, duties of health carriers, etc*	• **12 months**	• Prohibits a refund or offset against a claim more than 12 months after the carrier paid the claim, except in cases of fraud or misrepresentation by the health care provider.
MONTANA 33-22-150 *Reciprocal limitations on claim filing and claim audits – time limit for reimbursements or offsets – exceptions*	• **12 months**	• If an insurer limits the time to submit a claim for payment, the insurer has the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. • If the insurer *does not* limit the time required to submit a claim for payment, an insurer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.
NEVADA *(Codification Pending)* *695D* *687B*	• **12 months**	• 3. Except as otherwise provided in this subsection, an organization for dental care or an administrator who recovers overpayments under a plan for dental care shall not attempt to recover an overpayment more than 12 months after the date of the overpayment.

 Updated: 9/2/2021

Dental Insurance Reform
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NEW HAMPSHIRE 415:6-I; 415:18-M; 420-A:17-E; 420-J:8-B *Retroactive denials prohibited; exceptions*	• **12 months** • **18 months** • Depending on plan type	415:6-i (for *Accident and Sickness Policies*): • Insurer may impose retroactive denial of a previously paid claim as long as the time which has elapsed since the date of payment of the challenged claim does not exceed 12 months. 415:18-m (for *General Group or Blanket Policies*): • Insurer may impose retroactive denial of a previously paid claim as long as the time which has elapsed since the date of payment of the challenged claim does not exceed 18 months. 420-A:17-e (for *Health Service Corporations Policies*): • Insurer may impose retroactive denial of a previously paid claim as long as the time which has elapsed since the date of payment of the challenged claim does not exceed 18 months. 420-J:8-b (for *Health Carrier Policies*): • Insurer may impose retroactive denial of a previously paid claim as long as the time which has elapsed since the date of payment of the challenged claim does not exceed 12 months.
NEW YORK INSURANCE LAW ARTICLE 32 § 3224-B (B) (3) *Rules relating to the processing of health claims and overpayments to physicians*	• **24 months**	• A health plan shall not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider.
NORTH DAKOTA 26.1-47-02.3. *Post payment of dental claims – payment recovery limitations*	• **12 months**	• A dental carrier may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made.
OHIO § 3901.388 *Finality of payments; recovery of overpayments*	• **24 months**	• Payments made by third-party payers to health care providers shall be considered final two years after the payment is made and may not be adjusted, unless the provider has committed fraud.

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Dental Insurance Reform
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OREGON 743B.451 (2)(A)(A) *Refund of paid claims*	• **18 months** • **30 months,** coordination of benefits (3)(a)(A)	• Prohibits health insurers from requesting a refund of a payment previously made to satisfy a claim unless the health insurer requests the refund on or before the last day of the period specified by the contract with the health care provider or 18 months after the date the payment was made, whichever is earlier. • Time limit moves to 30 months for coordination of benefits transactions.
PENNSYLVANIA § 3803. *Retroactive denial of reimbursement*	• **24 months**	• An insurer may not retroactively deny reimbursement as a result of an overpayment determination more than 24 months after the date the insurer initially paid the health care provider.
RHODE ISLAND § 27-20.1-19. *Post-payment audits*	• **18 months**	• Any review, audit or investigation by a nonprofit dental service corporation of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care must be completed no later than 18 months after the completed claims were initially paid.
TENNESSEE 56-7-110 (C) & (F) *Part definitions – correction of payment errors – retroactive denial of reimbursements*	• **18 months**	• Except in cases of fraud committed by the health care provider, a health insurance entity may only recoup reimbursements to the provider during the 18-month period after claim payment. • The time to seek recovery is six months when the health insurance entity has verified that an individual is a covered person and the provider renders services in reliance on the verification.
UTAH 31A-26-301.6 (14) *Health care claims practices*	• **12 months** • **24 months,** coordination of benefits • **36 months,** publicly funded	• Limits overpayment recovery to 12 months after payment. • Increases to 24 months for overpayments involving coordination of benefits. • Increases to 36 months for overpayments involving Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program.

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Dental Insurance Reform
Retroactive Denials

STATES	TIME LIMIT	STATUTE (*)
WASHINGTON 48.43.600 (1) (2) *Overpayment recovery – carrier*	• **24 months** • **30 months,** coordination of benefits	• Prohibits carrier from requesting a refund from a health care provider of a payment previously made to satisfy a claim unless it does so within 24 months after the date that the payment was made. • Increases to 30 months for overpayments involving coordination of benefits. • A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim, request that a contested refund be paid any sooner than six months after receipt of the request.

(*) Statute: Time limitations vary for unique types of transactions such as Coordination of Benefits and Publicly Funded Programs. Transactions where fraud or duplicate payments from the same insurer may not have time limitations.