§ 2730. Collection of overpayments by health insurers and health plans: Insurance Contracts Generally

(a) Other than recovery for duplicate payments, a health insurer or health plan, whenever it engages in overpayment recovery efforts, shall provide written notice to the health-care provider that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

(b) A health insurer or health plan shall provide a health-care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for health-care providers to follow to challenge an overpayment recovery.

(c) A health insurer or health plan shall not initiate overpayment recovery efforts more than 24 months after the original payment for the claim was made. No such time limit shall apply to overpayment recovery efforts which are:

(1) Based on a reasonable belief of fraud, abuse, or other intentional misconduct;

(2) Required by, or initiated at the request of, a self-insured plan; or

(3) Required by a state or federal government plan.

(d) Nothing in this section shall be deemed to limit a health insurer’s or health plan’s right to pursue recovery of overpayments that occurred prior to June 14, 2018, where the health insurer or health plan has provided the health-care provider with notice of such recovery efforts prior to June 14, 2018.

(e) For purposes of this section “health insurer” shall mean any entity or plan that provides health insurance in this State. Such terms shall include an insurance company, health service corporation, managed care organization, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. “Health insurer” shall also include any third-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

(f) For purposes of this section, “health plan” shall mean any hospital or medical policy or certificate, major-medical expense insurance, health service corporation subscriber contract, health maintenance organization subscriber contract, managed care organization subscriber contract, dental or vision plan. “Health plan” does not include accident-only, credit, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance or automobile medical payment insurance.
(g) Waiver prohibited. — The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.