304.17A-708 Resolution of payment errors -- Retroactive denial of claims -- Conditions.

(1) An insurer shall not require a provider to appeal errors in payment where the insurer has not paid the claim according to the contracted rate. Miscalculations in payments made by the insurer shall be corrected and paid within thirty (30) calendar days upon the insurer's receipt of documentation from the provider verifying the error.

(2) An insurer shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.

(3) (a) Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the twenty-four (24) month period after the date that the insurer paid the claim submitted by the provider.

(b) An insurer that retroactively denies reimbursement to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial.

(c) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall specify the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) If an insurer retroactively denies reimbursement for services as a result of coordination of benefits with another insurer, the provider shall have twelve (12) months from the date that the provider received notice of the denial, unless the insurer that retroactively denied reimbursement permits a longer period, to submit a claim for reimbursement for the service to the insurer, the medical assistance program, or the Medicare program responsible for payment.

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