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2011-2012 Regular Sessions

I N  S E N A T E

(PREFILED)

January 5, 2011

Introduced by Sen. MAZIARZ -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to establishing procedures for the collection of overpayments from health care providers based upon eligibility of the insured; and requiring insurers to notify health care professionals by written and electronic formats regarding particular billing codes; and requiring contracts entered into with a health care provider to include certain information

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 3224-a of the insurance law is amended by adding a new subsection (b-1) to read as follows:

(B-1) WHERE AN INSURER OR ORGANIZATION OR CORPORATION SEEKS A REFUND FROM A HEALTH CARE PROVIDER OF A PAYMENT PREVIOUSLY MADE FOR HEALTH CARE SERVICES:

(1) IN A CASE WHERE AN INSURER OR ORGANIZATION OR CORPORATION IS SEEKING A REFUND FOR PAYMENT PREVIOUSLY MADE BASED UPON A GOOD FAITH BELIEF REGARDING THE ELIGIBILITY OF A PERSON FOR COVERAGE, OR THE LIABILITY OF ANOTHER INSURER OR CORPORATION OR ORGANIZATION FOR ALL OR PART OF THE CLAIM, THE INSURER OR ORGANIZATION OR CORPORATION MUST NOTIFY THE HEALTH CARE PROVIDER IN WRITING THE AMOUNT OF THE REFUND BEING SOUGHT, THE SPECIFIC REASONS WHY THE REFUND IS BEING SOUGHT, AND ANY INFORMATION IT MAY HAVE REGARDING ANOTHER INSURER, ORGANIZATION, CORPORATION OR OTHER ENTITY THAT MAY BE LEGALLY OBLIGATED TO MAKE PAYMENT. IF THE INSURER, ORGANIZATION OR CORPORATION SEEKING THE REFUND DOES NOT MAINTAIN ANY SUCH INFORMATION, IT SHALL SO STATE ON THE NOTICE TO THE HEALTH CARE PROVIDER. NOTICE OF SUCH REFUND DEMAND SHALL BE MADE AS SOON AS REASONABLY PRACTICABLE AFTER RECEIPT OF INFORMATION THAT SUCH INSURER, ORGANIZATION OR CORPORATION WAS NOT RESPONSIBLE FOR PAYMENT. FAILURE TO IDEN-

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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TIFY SUCH OTHER RESPONSIBLE PAYOR WHERE SUCH INFORMATION IS KNOWN TO THE INSURER, OR ORGANIZATION OR CORPORATION, OR FAILURE TO TIMELY NOTIFY THE HEALTH CARE PROVIDER ONCE SUCH INFORMATION IS RECEIVED REGARDING THAT SUCH INSURER, ORGANIZATION OR CORPORATION WAS NOT RESPONSIBLE FOR PAYMENT, SHALL BAR SUCH INSURER, ORGANIZATION OR CORPORATION FROM ATTEMPTING TO OBTAIN THE REFUND OF THE PREVIOUS PAYMENT. THE HEALTH CARE PROVIDER FROM WHOM THE REFUND IS SOUGHT MAY SUBMIT SUCH CLAIM TO THE LEGALLY RESPONSIBLE INSURER, CORPORATION OR ORGANIZATION FOR PAYMENT. FOR THE PURPOSES OF COMPLYING WITH ANY TIME LIMITATION THE INSURER, ORGANIZATION OR CORPORATION LEGALLY RESPONSIBLE FOR PAYMENT MAY HAVE REGARDING THE SUBMISSION OF CLAIMS, THE DATE OF NOTICE OF THE REFUND DEMAND FROM THE INSURER, ORGANIZATION OR CORPORATION SEEKING THE REFUND SHALL BE DEEMED TO BE THE DATE OF THE RENDERING OF HEALTH CARE SERVICES. SUCH TIME LIMITATION OF THE LEGALLY RESPONSIBLE INSURER, CORPORATION OR ORGANIZATION SHALL BE EXCUSED WHERE THE IDENTITY OF SUCH INSURER, CORPORATION OR ORGANIZATION CANNOT REASONABLY BE IDENTIFIED WITHIN THE TIME LIMITATION. ALL UTILIZATION REVIEW, AS DEFINED BY ARTICLE FORTY-NINE OF THIS CHAPTER AND ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW, PERFORMED BY THE INSURER, ORGANIZATION OR CORPORATION SEEKING THE REFUND SHALL BE BINDING ON THE LEGALLY RESPONSIBLE INSURER, ORGANIZATION OR CORPORATION TO WHOM THE HEALTH CARE PROVIDER SUBSEQUENTLY SUBMITS THE CLAIM. THE CLAIM SHALL NOT BE DENIED BY THE LEGALLY RESPONSIBLE INSURER, ORGANIZATION OR CORPORATION ON THE BASIS OF LACK OF AUTHORIZATION TO PROVIDE SUCH HEALTH CARE SERVICES.

(2) IN A CASE WHERE THE INSURER OR ORGANIZATION OR CORPORATION IS SEEKING THE REFUND BASED UPON A DETERMINATION REGARDING THE AMOUNT OF THE CLAIM PAID, SUCH INSURER MAY NOT ATTEMPT TO COLLECT SUCH PREVIOUS PAYMENT UNLESS THE FOLLOWING CAN BE DEMONSTRATED:

(I) THE INSURER, ORGANIZATION OR CORPORATION HAS IDENTIFIED IN WRITING THE FINDING OF EACH AND EVERY CLAIM REVIEWED SUFFICIENT TO GIVE THE HEALTH CARE PROVIDER REASONABLY SPECIFIC NOTICE WHY SUCH PREVIOUS PAYMENT WAS ALLEGEDLY INAPPROPRIATELY MADE;

(II) THE INSURER, ORGANIZATION OR CORPORATION PROVIDES TO THE HEALTH CARE PROVIDER A FULL AND MEANINGFUL OPPORTUNITY TO CHALLENGE THE FINDINGS ON THE CLAIMS REVIEWED PRIOR TO THE COMMENCEMENT OF ANY ADVERSARIAL PROCEEDING TO COLLECT ANY SUCH PREVIOUS PAYMENT ALLEGEDLY INAPPROPRIATELY MADE; AND

(III) SUCH INSURER, ORGANIZATION OR CORPORATION HAS DETERMINED AND NOTIFIED THE HEALTH CARE PROVIDER IN WRITING IF THERE HAVE BEEN UNDERPAYMENTS TO SUCH HEALTH CARE PROVIDER AND THE FULL AMOUNT OF THE UNDERPAYMENTS HAVE BEEN SUBTRACTED FROM THE TOTAL AMOUNT OF PREVIOUS PAYMENTS ALLEGEDLY INAPPROPRIATELY MADE.

(3) IN NO EVENT MAY AN INSURER, ORGANIZATION OR CORPORATION, WITHOUT THE CONSENT OF THE HEALTH CARE PROVIDER FROM WHOM THE REFUND IS SOUGHT, USE EXTRAPOLATION TO DETERMINE THE TOTAL OF SUCH PREVIOUS PAYMENTS ALLEGEDLY INAPPROPRIATELY MADE. SUCH CONSENT MAY NOT BE OBTAINED BY INCLUSION IN THE GENERAL CONTRACT OF THE HEALTH CARE PROVIDER WITH THE INSURER, ORGANIZATION OR CORPORATION. IF EXTRAPOLATION IS USED TO DETERMINE THE TOTAL AMOUNT THE INSURER, ORGANIZATION OR CORPORATION MUST, IN ADDITION TO MEETING THE REQUIREMENTS OF PARAGRAPH TWO OF THIS SUBSECTION:

(I) PROVIDE INFORMATION TO THE HEALTH CARE PROVIDER HOW THE SAMPLE OF CLAIMS WAS SELECTED UPON WHICH THE EXTRAPOLATED TOTAL WAS DETERMINED, AS WELL AS THE ERROR RATE;

(II) DEMONSTRATE THAT THE SAMPLE OF CLAIMS REVIEWED WAS SUFFICIENT IN SIZE TO PERMIT A GENERALIZATION FOR ALL CLAIMS SUBMITTED DURING THE TIME PERIOD UNDER REVIEW;

(III) IDENTIFY THE FINDINGS OF EACH AND EVERY CLAIM REVIEWED IN SUCH SUFFICIENT DETAIL AS TO APPRISE THE HEALTH CARE PROVIDER WHY IT WAS DETERMINED THAT THE PREVIOUS PAYMENT WAS ALLEGEDLY INAPPROPRIATELY MADE;

(IV) ASSURE THAT THE FINDINGS OF THE CLAIMS REVIEWED ARE NOT EXTRAPOLATED TO CLAIMS THAT WERE SUBMITTED OUTSIDE OF THE PERIOD OF TIME THAT CLAIMS WERE REVIEWED;

(V) PROVIDE TO THE HEALTH CARE PROVIDER A FULL AND MEANINGFUL OPPORTUNITY TO CHALLENGE THE FINDINGS ON THE CLAIMS REVIEWED, AS WELL AS THE MANNER BY WHICH THE TOTAL AMOUNT OF PREVIOUS PAYMENTS ALLEGEDLY INAPPROPRIATELY MADE WAS DETERMINED, PRIOR TO THE COMMENCEMENT OF ANY ADVERSARIAL PROCEEDING TO COLLECT ANY SUCH INAPPROPRIATE PREVIOUS PAYMENTS; AND

(VI) DETERMINED IF THERE HAVE BEEN UNDERPAYMENTS TO SUCH HEALTH CARE PROVIDER AND THOSE AMOUNTS HAVE BEEN USED TO OFFSET ANY RESPONSIBILITY OF THE HEALTH CARE PROVIDER TO REPAY THE PREVIOUS PAYMENTS ALLEGEDLY INAPPROPRIATELY MADE.

(4) IN NO EVENT MAY A REFUND FOR A PREVIOUS PAYMENT BE SOUGHT WHERE UTILIZATION REVIEW PURSUANT TO ARTICLE FORTY-NINE OF THIS CHAPTER OR ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW HAVE BEEN PERFORMED, EXCEPT AS PROVIDED IN PARAGRAPH ONE OF THIS SUBSECTION.

(5) IN NO EVENT MAY A REFUND FOR A PREVIOUS PAYMENT BE SOUGHT EXCEPT AS OTHERWISE PROVIDED BY THIS SUBSECTION.

(6) IN NO EVENT MAY AN INSURER, ORGANIZATION OR CORPORATION, WITHOUT THE CONSENT OF THE HEALTH CARE PROVIDER, ATTEMPT TO OBTAIN SUCH PREVIOUS PAYMENTS DETERMINED TO HAVE BEEN INAPPROPRIATELY MADE, AS SET FORTH IN THIS SUBSECTION, BY OFFSETTING FUTURE PAYMENTS DUE TO SUCH HEALTH CARE PROVIDER. SUCH CONSENT MAY NOT BE OBTAINED BY INCLUSION IN THE GENERAL CONTRACT BETWEEN THE HEALTH CARE PROVIDER AND THE INSURER, ORGANIZATION OR CORPORATION.

(7) THE HEALTH CARE PROVIDER SHALL BE GIVEN A PERIOD OF TIME OF NO LESS THAN SIX MONTHS TO REFUND PREVIOUS PAYMENTS THAT HAVE BEEN, AS SET FORTH IN THIS SUBSECTION, DETERMINED TO BE INAPPROPRIATELY MADE.

S 2. Subsection (d) of section 4803 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(d) An insurer shall develop and implement policies and procedures to ensure that health care providers participating in the [the] in-network benefits portion of an insurer's network for a managed care product are regularly informed of information maintained by the insurer to evaluate the performance or practice of the health care professional. The insurer shall consult with health care professionals in developing methodologies to collect and analyze provider profiling data. Insurers shall provide any such information and profiling data and analysis to these health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. SUCH INFORMATION, DATA AND ANALYSIS SHALL BE PROVIDED TO THE SUPERINTENDENT AT THE SAME TIME SUCH INFORMATION, DATA AND ANALYSIS IS PROVIDED TO HEALTH CARE PROFESSIONALS. Any profiling data used to evaluate the performance or practice of such a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each such health care professional shall be given the opportunity to discuss the unique nature of the

health care professional's patient population which may have a bearing on the professional's profile and to work cooperatively with the insurer to improve performance. AN INSURER SHALL, ON A PERIODIC BASIS, NOTIFY HEALTH CARE PROFESSIONALS BY WRITTEN AND ELECTRONIC FORMATS REGARDING PARTICULAR BILLING CODES USED BY HEALTH CARE PROFESSIONALS WHICH MAY BE OVERUTILIZED OR INAPPROPRIATELY UTILIZED. SUCH NOTIFICATION SHALL BE A CONDITION PRECEDENT TO TAKE ANY ACTION TO RECOUP PREVIOUSLY PAID PAYMENTS UNDER SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THIS CHAPTER.

S 3. Subdivision 4 of section 4406-d of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

4. A health care plan shall develop and implement policies and procedures to ensure that health care professionals are regularly informed of information maintained by the health care plan to evaluate the performance or practice of the health care professional. The health care plan shall consult with health care professionals in developing methodologies to collect and analyze health care professional profiling data. Health care plans shall provide any such information and profiling data and analysis to health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. SUCH INFORMATION, DATA AND ANALYSIS SHALL ALSO BE PROVIDED TO THE DEPARTMENT AT THE SAME TIME THE INFORMATION, DATA AND ANALYSIS IS PROVIDED TO HEALTH CARE PROFESSIONALS. Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the health care professional's profile and to work cooperatively with the health care plan to improve performance. A HEALTH CARE PLAN SHALL, ON A PERIODIC BASIS, NOTIFY HEALTH CARE PROFESSIONALS BY WRITTEN AND ELECTRONIC FORMATS REGARDING PARTICULAR BILLING CODES USED BY HEALTH CARE PROFESSIONALS WHICH MAY BE OVERUTILIZED OR INAPPROPRIATELY UTILIZED. SUCH NOTIFICATION SHALL BE A CONDITION PRECEDENT TO TAKING ANY ACTION TO RECOUP PAYMENTS PREVIOUSLY PAID AS PROVIDED UNDER SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW.

S 4. Subsection (e) of section 3217-b of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(e) Contracts entered into between an insurer and a health care provider shall include terms which prescribe:

(1) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(2) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

(3) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(4) the process to be employed to resolve disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that

nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; [and]

(5) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contracts through a proceeding under article seventy-five of the civil practice law and rules;

(6) THAT THE INSURER WILL NOTIFY THE PROVIDER, ELECTRONICALLY AND IN WRITING, AS SOON AS REASONABLY PRACTICABLE, OF SPECIFIC CHANGES TO THE APPLICABLE PAYMENT SCHEDULE AND/OR SPECIFIC CHANGES TO THE MANNER BY WHICH PAYMENTS WILL BE CALCULATED;

(7) THAT A PROVIDER CAN OBTAIN SPECIFIC INFORMATION FROM THE INSURER REGARDING THE PAYMENT FOR A PARTICULAR SERVICE OR SERVICES, OR THE MANNER BY WHICH PAYMENTS WILL BE CALCULATED, BY SUBMITTING A REQUEST IN WRITING OR BY SUBMITTING A REQUEST VIA ELECTRONIC MEANS; AND

(8) THAT THE PROVIDER WILL BE ABLE TO OBTAIN THE MOST CURRENT INFORMATION MAINTAINED BY THE INSURER REGARDING THE ELIGIBILITY OF A PARTICULAR PATIENT TO RECEIVE COVERED SERVICES. A VIOLATION OR FAILURE TO PERFORM ANY OBLIGATION IMPOSED UNDER THIS SECTION SHALL RESULT IN A CIVIL PENALTY NOT TO EXCEED ONE THOUSAND DOLLARS FOR EACH SUCH VIOLATION OR FAILURE.

S 5. Subdivision 5-a of section 4406-c of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

5-a. Contracts entered into between a plan and a health care provider shall include terms which prescribe:

(a) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(b) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

(c) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(d) the process to be employed to [resolved] RESOLVE disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; [and]

(e) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contract through a proceeding under article seventy-five of the civil practice law and rules;

(F) THAT THE PLAN WILL NOTIFY THE PROVIDER, ELECTRONICALLY AND IN WRITING, AS SOON AS REASONABLY PRACTICABLE, OF SPECIFIC CHANGES TO THE APPLICABLE PAYMENT SCHEDULE AND/OR SPECIFIC CHANGES TO THE MANNER BY WHICH PAYMENTS WILL BE CALCULATED;

(G) THAT THE PROVIDER CAN OBTAIN SPECIFIC INFORMATION FROM THE PLAN REGARDING THE PAYMENT FOR A PARTICULAR SERVICE OR SERVICES, OR THE MANNER BY WHICH PAYMENTS WILL BE CALCULATED, BY SUBMITTING A REQUEST IN WRITING OR BY SUBMITTING A REQUEST VIA ELECTRONIC MEANS; AND

(H) THAT THE PROVIDER WILL BE ABLE TO OBTAIN THE MOST CURRENT INFORMATION MAINTAINED BY THE PLAN REGARDING THE ELIGIBILITY OF A PARTICULAR PATIENT TO RECEIVE COVERED SERVICES. A VIOLATION OR FAILURE TO PERFORM ANY OBLIGATION IMPOSED UNDER THIS SECTION SHALL RESULT IN A CIVIL PENALTY NOT TO EXCEED ONE THOUSAND DOLLARS FOR EACH SUCH VIOLATION OR FAILURE.

S 6. This act shall take effect on the sixtieth day after it shall have become a law.