S T A T E O F N E W Y O R K

3340

2009-2010 Regular Sessions

I N A S S E M B L Y

January 27, 2009

Introduced by M. of A. BRADLEY, J. RIVERA, MAISEL, PAULIN, FIELDS, JAFFEE, GUNTHER, ROBINSON, MILLMAN, ZEBROWSKI -- Multi-Sponsored by -- M. of A. BOYLAND, COOK, EDDINGTON, GALEF, GLICK, GOTTFRIED, HYER-SPENCER, MAYERSOHN, REILLY, SCHIMEL, SWEENEY, WEISENBERG -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to processing of health claims and overpayments to certain health care providers

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

Section 1. Section 3224-b of the insurance law, as added by chapter 551 of the laws of 2006, is amended to read as follows:

S 3224-b. Rules relating to the processing of health claims and overpayments to physicians AND GENERAL HOSPITALS. (a) Processing of health care claims. This subsection is intended to provide uniformity and consistency in the reporting of medical services and procedures as they relate to the processing of health care claims and is not intended to dictate reimbursement policy.

(1) For purposes of this section, a "health plan" shall be defined as an insurer that is licensed to write accident and health insurance, or that is licensed pursuant to article forty-three of this chapter or is certified pursuant to article forty-four of the public health law. THE TERM "GENERAL HOSPITAL" SHALL HAVE THE SAME MEANING AS IN ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW.

(2) Subject to the provisions of paragraph three of this subsection, a health plan shall accept and initiate the processing of all health care claims submitted by a physician OR A GENERAL HOSPITAL pursuant to and consistent with the current version of the American medical association's current procedural terminology (CPT) codes, reporting guidelines and conventions and the centers for medicare and medicaid services healthcare common procedure coding system (HCPCS).

(3) Nothing in this section shall preclude a health plan from determining that any such claim is not eligible for payment, in full or in part, based on a determination that: (i) the claim is not complete as defined by 11 NYCRR 217; (ii) the service provided is not a covered

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

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benefit under the contract or agreement, including but not limited to, a determination that such service is not medically necessary or is experimental or investigational; (iii) the insured did not obtain a referral, pre-certification or satisfy any other condition precedent to receive covered benefits from the physician; (iv) the covered benefit exceeds the benefit limits of the contract or agreement; (v) the person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her contract; (vi) another insurer, corporation or organization is liable for all or part of the claim; or (vii) the plan has a reasonable suspicion of fraud or abuse. In addition, nothing in this section shall be deemed to require a health plan to pay or reimburse a claim, in full or in part, or dictate the amount of a claim to be paid by a health plan to a physician OR GENERAL HOSPITAL.

(4) Every health plan shall publish on its provider website and in its provider newsletter the name of the commercially available claims editing software product that the health plan utilizes and any significant edits, as determined by the health plan, added to the claims software product after the effective date of this section, which are made at the request of the health plan. The health plan shall also provide such information upon the written request of a physician OR GENERAL HOSPITAL who is a participating [physician] PROVIDER in the health plan's provider network.

(b) Overpayments to physicians AND GENERAL HOSPITALS. (1) Other than recovery for duplicate payments, a health plan shall provide thirty days written notice to physicians AND GENERAL HOSPITALS before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims to such physicians AND GENERAL HOSPITALS. Such notice shall state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

(2) A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a physician OR GENERAL HOSPITAL. Provided, however, that no such time limit shall apply to overpayment recovery efforts which are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required by a state or federal government program. Notwithstanding the aforementioned time limitations, in the event that a physician OR GENERAL HOSPITAL asserts that a health plan has underpaid a claim or claims, the health plan may defend or set off such assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For purposes of this paragraph, "abusive billing" shall be defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.

(3) Nothing in this section shall be deemed to limit [an insurer's] A HEALTH PLAN'S right to pursue recovery of overpayments that occurred prior to the effective date of this section where the [insurer] HEALTH PLAN has provided the physician OR GENERAL HOSPITAL with notice of such recovery efforts prior to the effective date of this section.

S 2. This act shall take effect January 1, 2010 and shall apply to physician and general hospital claims submitted for payment on or after such date.