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

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2009-2010 Regular Sessions

I N A S S E M B L Y

January 27, 2009

Introduced by M. of A. BRADLEY, FIELDS, BALL, DelMONTE, LIFTON, ENGLEBRIGHT, ALESSI, LANCMAN -- Multi-Sponsored by -- M. of A. BOYLAND, KOON, McENENY, PHEFFER, SWEENEY -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to the rights of health care providers under managed care contracts, to rules relating to the processing of health claims, and to alleged overpayments to physicians

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

Section 1. Subsection (a) of section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed TO WRITE ACCIDENT OR HEALTH INSURANCE OR LICENSED or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within [forty-five] THIRTY days of receipt of a PAPER claim or bill for services rendered. AN INSURER OR AN ORGANIZATION OR CORPORATION LICENSED TO WRITE ACCIDENT OR HEALTH INSURANCE OR LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL MAKE PAYMENT WITHIN FIFTEEN DAYS OF RECEIPT FOR ELECTRONICALLY SUBMITTED CLAIMS. A HEALTH CARE PROVIDER WHO SUBMITS CLAIMS ELECTRONICALLY SHALL HAVE THE OPTION OF GETTING PAID ELECTRONICALLY.

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

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S 2. 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 RIGHTS OF PHYSICIANS UNDER MANAGED CARE CONTRACTS, the processing of health claims and [overpayments] PAYMENTS to physicians. (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] ALL AGREEMENTS BETWEEN HEALTH PLANS AND PHYSICIANS FOR THE DELIVERY OF MEDICAL SERVICES TO HEALTH PLAN BENEFICIARIES MUST CONTAIN AND CONFORM TO THIS SECTION'S RULES WITH RESPECT TO THE RIGHTS OF PHYSICIANS UNDER MANAGED CARE CONTRACTS.

(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.

(2) ALL CONTRACTS, INCLUDING AMENDMENTS THERETO, MUST BE SIGNED BY BOTH PARTIES AND SHALL HAVE ATTACHED A COMPLETE FEE SCHEDULE APPROPRIATE TO THE PHYSICIAN'S SPECIALTY.

(3) NO CONTRACT MAY COMPEL THE PHYSICIAN TO PARTICIPATE IN ANY FUTURE PRODUCTS OFFERED BY THE PAYER.

(4) AN INSURER MAY ONLY TERMINATE THE CONTRACT PRIOR TO THE AGREED UPON DATE OF EXPIRATION ON A FOR CAUSE BASIS. REFUSAL TO SIGN A CONTRACT AMENDMENT SHALL NOT BE DEEMED CAUSE FOR TERMINATION.

(5) THERE SHALL BE A MINIMUM OF ONE HUNDRED FIFTY DAYS ADVANCED WRITTEN NOTICE OF A CONTRACT'S NON-RENEWAL.

(6) INSURERS SHALL PROVIDE PHYSICIANS WITH A MINIMUM OF NINETY DAYS ADVANCED WRITTEN NOTICE OF CHANGES IN POLICIES AND PROCEDURES EXCEPT WHERE SUCH POLICY OR PROCEDURE CHANGE RESULTS IN A MATERIAL ADVERSE IMPACT ON A PHYSICIAN'S ADMINISTRATIVE COSTS OR ON THE INSURER'S TOTAL AGGREGATE LEVEL OF PAYMENT TO A PHYSICIAN, IN WHICH CASE SUCH A CHANGE MAY ONLY BE EFFECTUATED THROUGH A CONTRACT AMENDMENT.

(7) INSURERS MAY NOT ASSIGN, LEASE OR CONVEY RIGHTS IN A CONTRACT WITH THE PHYSICIAN TO AN UNRELATED PARTY WITHOUT THE PHYSICIAN'S WRITTEN CONSENT IN EACH INSTANCE OF SUCH PROPOSED ASSIGNMENT, LEASE, OR CONVEYANCE UNLESS SUCH ASSIGNMENT, LEASE, OR CONVEYANCE IS TO A PARENT, AFFILIATE, OR SUBSIDIARY CORPORATION OR TO A TRANSFEREE OF ALL OR SUBSTANTIALLY ALL OF SUCH INSURER'S ASSETS.

(8) INSURERS SHALL INDEMNIFY A PHYSICIAN FOR ANY DAMAGES FOR MEDICAL LIABILITY RESULTING FROM THE PHYSICIAN'S COMPLIANCE WITH A PAYER'S UTILIZATION REVIEW DECISIONS.

(9) (A) INSURERS SHALL UTILIZE CURRENT ICD-9-CM DIAGNOSES CODES AND CURRENT PROCEDURAL TERMINOLOGY (CPT) PROCEDURE CODES TO DESCRIBE PHYSICIAN SERVICES RENDERED FOR PROCESSING CLAIMS RELATED THERETO FOR PAYMENT APPLYING OFFICIAL CODING RULES AND GUIDELINES INCLUDING THOSE APPLYING TO BUNDLING AND UNBUNDLING OF CODES AND SERVICES.

(B) Subject to the provisions of paragraph [three] TEN of this subsection, a health plan shall accept and initiate the processing of all health care claims submitted by a physician 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) INCLUDING BUNDLED AND UNBUNDLED SERVICES.

[(3)] (10) 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 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.]

[(4)] (11) 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 who is a participating physician in the health plan's provider network.

(b) Overpayments to physicians. (1) Other than recovery for duplicate payments, a health plan shall provide thirty days written notice to physicians before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims to such physicians. 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. 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 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 A PHYSICIAN'S 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. EVERY INSTANCE OF ALLEGED ABUSIVE BILLING SHALL BE SUBSTANTIATED BY A REVIEW OF THE MEDICAL RECORD PERTAINING TO EACH CLAIM FOR WHICH FINANCIAL RECOVERY IS SOUGHT. WHEN THERE IS A DISPUTE BETWEEN AN INSURER AND PHYSICIAN OVER WHETHER OR NOT A CLAIM CONSTITUTES ABUSIVE BILLING, IT SHALL BE REFERRED TO AND RESOLVED BY THE INDEPENDENT DISPUTE RESOLUTION REVIEW BOARD AS SPECIFIED IN PARAGRAPH EIGHT OF THIS SUBSECTION. NOTWITHSTANDING ANY LIMITATIONS WRITTEN INTO EXISTING CONTRACTS BETWEEN AN INSURER AND A PHYSICIAN, PHYSICIANS MAY OFFSET SUCH INSURER OVERPAYMENT CLAIMS WITH INSTANCES OF DOCUMENTED UNDERPAYMENT DURING THE PERIOD IN QUESTION.

(3) [Nothing in this section shall be deemed to limit an insurer's right to pursue recovery of overpayments that occurred prior to the effective date of this section where the insurer has provided the physician with notice of such recovery efforts prior to the effective date of this section.] ALL CLAIMS FOR ALLEGED OVERPAYMENTS SHALL BE BASED ON AUDITS OF MEDICAL RECORDS FOR EACH CLAIM FOR WHICH AN OVERPAYMENT IS ALLEGED AND MAY NOT BE EXTRAPOLATED FROM A SAMPLE OF CLAIMS.

(4) INSURERS MAY NOT RECOUP CLAIMED OVERPAYMENTS BY OFFSETTING REIMBURSEMENT OWED FOR SERVICES RENDERED TO OTHER PATIENTS.

(5) WHERE THE INSURER HAS CONFIRMED THE ELIGIBILITY OF A PATIENT'S COVERAGE PRIOR TO THE PROVISION OF SERVICES BY A PHYSICIAN WHO IN GOOD FAITH RELIED UPON SUCH INSURER VERIFICATION, INSURER MAY NOT SUBSEQUENTLY SEEK FINANCIAL RECOVERY FROM A PHYSICIAN FOR SUCH RENDERED SERVICES ON THE GROUNDS THAT THE PATIENT WAS NOT COVERED BY THE INSURER.

(6) INSURERS SHALL PAY PHYSICIANS THE AVERAGE SALES PRICE (ASP) FORMULA ESTABLISHED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) PURSUANT TO SECTION 1847A OF THE SOCIAL SECURITY ACT, FOR THE COST OF ACQUIRING COVERED VACCINES, BIOLOGICALS, AND OTHER INJECTABLE MEDICATIONS.

(7) INSURERS SHALL NOT REDUCE THE LEVEL OF ICD-9-CM/CPT CODES FOR BILLED COVERED SERVICES WITHOUT FIRST PERFORMING AN AUDIT REVIEW OF ALL THE PERTINENT PATIENT MEDICAL RECORDS.

(8) THE SUPERINTENDENT SHALL ESTABLISH AN INDEPENDENT DISPUTE RESOLUTION REVIEW BOARD WITHIN OR UNDER THE AUSPICES OF THE DEPARTMENT AUTHORIZED TO HEAR AND RESOLVE INSURER-PHYSICIAN BILLING DISPUTES BROUGHT BY EITHER THE INSURER OR THE PHYSICIAN. THE SUPERINTENDENT SHALL ESTABLISH A CASE ADMINISTRATION FEE TO COVER THE COST INCURRED BY THE DISPUTE REVIEW BOARD (INCLUDING EXPERT ICD-9-CM/CPT CODING CONSULTANTS) IN REVIEWING AND DECIDING A BILLING DISPUTE. THIS FEE IS TO BE BORNE BY THE PARTY WHO LOSES THE DISPUTE DECISION.

(9) INSURERS THAT SELL HEALTH SAVINGS ACCOUNTS PRODUCTS AS DEFINED IN 26 USC 223 SHALL CREATE AND MAINTAIN AN INTERNET WEB SITE CONTAINING THE LISTING OF INDIVIDUAL COSTS OF PARTICULAR MEDICAL SERVICES AND PROCEDURES INCLUDING USUAL, CUSTOMARY AND REASONABLE CHARGES FOR PHYSICIANS AND HOSPITALS REFERENCING UPDATED CURRENT PROCEDURE TERMINOLOGY (CPT) CODES AND SHALL MAKE AUTOMATED ACCESS TO CURRENT PATIENT HEALTH SAVINGS ACCOUNTS DEDUCTIBLE INFORMATION AVAILABLE TO PHYSICIANS AND PATIENTS.

S 3. This act shall take effect immediately and shall apply to all contracts entered into, renewed (automatically or otherwise), modified or amended on or after such date.