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I N A S S E M B L Y

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Introduced by M. of A. BING, JOHN, PAULIN, BENJAMIN, REILLY, JAFFEE, SKARTADOS, CASTRO -- Multi-Sponsored by -- M. of A. CHRISTENSEN, COOK, GALEF, KOON, MAGEE, M. MILLER, PHEFFER, SPANO, 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, rules relating to the processing of health claims, and alleged overpayments to physicians

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

1 Section 1. Subsection (a) of section 3224-a of the insurance law, as
2 amended by chapter 237 of the laws of 2009, is amended to read as
3 follows:
4 (a) Except in a case where the obligation of an insurer or an organ-
5 ization or corporation licensed TO WRITE ACCIDENT OR HEALTH INSURANCE OR
6 LICENSED or certified pursuant to article forty-three or forty-seven of
7 this chapter or article forty-four of the public health law to pay a
8 claim submitted by a policyholder or person covered under such policy
9 ("covered person") or make a payment to a health care provider is not
10 reasonably clear, or when there is a reasonable basis supported by
11 specific information available for review by the superintendent that
12 such claim or bill for health care services rendered was submitted frau-
13 dulently, such insurer or organization or corporation shall pay the
14 claim to a policyholder or covered person or make a payment to a health
15 care provider within thirty days of receipt of a claim or bill for
16 services rendered that is transmitted via the internet or electronic
17 mail, or [forty-five] THIRTY days of receipt of a claim or bill for
18 services rendered that is submitted by other means, such as paper or
19 facsimile. AN INSURER OR AN ORGANIZATION OR CORPORATION LICENSED TO
20 WRITE ACCIDENT OR HEALTH INSURANCE OR LICENSED OR CERTIFIED PURSUANT TO
21 ARTICLE FORTY-THREE OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC
22 HEALTH LAW SHALL MAKE PAYMENT WITHIN FIFTEEN DAYS OF RECEIPT FOR ELEC-
23 TRONICALLY SUBMITTED CLAIMS. A HEALTH CARE PROVIDER WHO SUBMITS CLAIMS
24 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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1 S 2. Section 3224-b of the insurance law, as added by chapter 551 of
2 the laws of 2006, subsection (b) as amended by chapter 237 of the laws
3 of 2009, is amended to read as follows:

4 S 3224-b. Rules relating to THE RIGHTS OF PHYSICIANS UNDER MANAGED
5 CARE CONTRACTS, the processing of health claims and [overpayments]
6 PAYMENTS to physicians. (a) [Processing of health care claims. This
7 subsection is intended to provide uniformity and consistency in the
8 reporting of medical services and procedures as they relate to the proc-
9 essing of health care claims and is not intended to dictate reimburse-
10 ment policy] ALL AGREEMENTS BETWEEN HEALTH PLANS AND PHYSICIANS FOR THE
11 DELIVERY OF MEDICAL SERVICES TO HEALTH PLAN BENEFICIARIES MUST CONTAIN
12 AND CONFORM TO THIS SECTION'S RULES WITH RESPECT TO THE RIGHTS OF PHYSI-
13 CIANS UNDER MANAGED CARE CONTRACTS.

14 (1) For purposes of this section, a "health plan" shall be defined as
15 an insurer that is licensed to write accident and health insurance, or
16 that is licensed pursuant to article forty-three of this chapter or is
17 certified pursuant to article forty-four of the public health law.

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

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

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

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

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

34 (7) INSURERS MAY NOT ASSIGN, LEASE OR CONVEY RIGHTS IN A CONTRACT WITH
35 THE PHYSICIAN TO AN UNRELATED PARTY WITHOUT THE PHYSICIAN'S WRITTEN
36 CONSENT IN EACH INSTANCE OF SUCH PROPOSED ASSIGNMENT, LEASE, OR CONVEY-
37 ANCE UNLESS SUCH ASSIGNMENT, LEASE, OR CONVEYANCE IS TO A PARENT, AFFIL-
38 IATE, OR SUBSIDIARY CORPORATION OR TO A TRANSFEREE OF ALL OR SUBSTAN-
39 TIALY ALL OF SUCH INSURER'S ASSETS.

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

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

48 (B) Subject to the provisions of paragraph [three] TEN of this
49 subsection, a health plan shall accept and initiate the processing of
50 all health care claims submitted by a physician pursuant to and consist-
51 ent with the current version of the American medical association's
52 current procedural terminology (CPT) codes, reporting guidelines and
53 conventions and the centers for medicare and medicaid services health-
54 care common procedure coding system (HCPCS) INCLUDING BUNDLED AND UNBUN-
55 DLED SERVICES.

1 [(3)] (10) Nothing in this section shall preclude a health plan from
2 determining that any such claim is not eligible for payment, in full or
3 in part, based on a determination that: (i) the claim is not complete as
4 defined by 11 NYCRR 217; (ii) the service provided is not a covered
5 benefit under the contract or agreement, including but not limited to, a
6 determination that such service is not medically necessary or is exper-
7 imental or investigational; (iii) the insured did not obtain a referral,
8 pre-certification or satisfy any other condition precedent to receive
9 covered benefits from the physician; (iv) the covered benefit exceeds
10 the benefit limits of the contract or agreement; (v) the person is not
11 eligible for coverage or is otherwise not compliant with the terms and
12 conditions of his or her contract; (vi) another insurer, corporation or
13 organization is liable for all or part of the claim; or (vii) the plan
14 has a reasonable suspicion of fraud or abuse. [In addition, nothing in
15 this section shall be deemed to require a health plan to pay or reim-
16 burse a claim, in full or in part, or dictate the amount of a claim to
17 be paid by a health plan to a physician.

18 (4)] (11) Every health plan shall publish on its provider website and
19 in its provider newsletter the name of the commercially available claims
20 editing software product that the health plan utilizes and any signif-
21 icant edits, as determined by the health plan, added to the claims soft-
22 ware product after the effective date of this section, which are made at
23 the request of the health plan. The health plan shall also provide such
24 information upon the written request of a physician who is a participat-
25 ing physician in the health plan's provider network.

26 (b) Overpayments to health care providers. (1) Other than recovery for
27 duplicate payments, a health plan shall provide thirty days written
28 notice to health care providers before engaging in additional overpay-
29 ment recovery efforts seeking recovery of the overpayment of claims to
30 such health care providers. Such notice shall state the patient name,
31 service date, payment amount, proposed adjustment, and a reasonably
32 specific explanation of the proposed adjustment.

33 (2) A health plan shall provide a health care provider with the oppor-
34 tunity to challenge an overpayment recovery, including the sharing of
35 claims information, and shall establish written policies and procedures
36 for health care providers to follow to challenge an overpayment recov-
37 ery. Such challenge shall set forth the specific grounds on which the
38 provider is challenging the overpayment recovery.

39 (3) A health plan shall not initiate overpayment recovery efforts more
40 than twenty-four months after the original payment was received by a
41 health care provider. However, no such time limit shall apply to over-
42 payment recovery efforts that are: (i) based on a reasonable belief of
43 fraud or other intentional misconduct, or abusive billing, (ii) required
44 by, or initiated at the request of, a self-insured plan, or (iii)
45 required or authorized by a state or federal government program or
46 coverage that is provided by this state or a municipality thereof to its
47 respective employees, retirees or members. Notwithstanding the aforemen-
48 tioned time limitations, in the event that a health care provider
49 asserts that a health plan has underpaid a claim or claims, the health
50 plan may defend or set off such assertion of underpayment based on over-
51 payments going back in time as far as the claimed underpayment. For
52 purposes of this paragraph, "abusive billing" shall be defined as a
53 billing practice which results in the submission of claims that are not
54 consistent with A PHYSICIAN'S sound fiscal, business, or medical prac-
55 tices and at such frequency and for such a period of time as to reflect
56 a consistent course of conduct. EVERY INSTANCE OF ALLEGED ABUSIVE BILL-

1 ING SHALL BE SUBSTANTIATED BY A REVIEW OF THE MEDICAL RECORD PERTAINING
2 TO EACH CLAIM FOR WHICH FINANCIAL RECOVERY IS SOUGHT. WHEN THERE IS A
3 DISPUTE BETWEEN AN INSURER AND PHYSICIAN OVER WHETHER OR NOT A CLAIM
4 CONSTITUTES ABUSIVE BILLING, IT SHALL BE REFERRED TO AND RESOLVED BY THE
5 INDEPENDENT DISPUTE RESOLUTION REVIEW BOARD AS SPECIFIED IN PARAGRAPH
6 EIGHT OF THIS SUBSECTION. NOTWITHSTANDING ANY LIMITATIONS WRITTEN INTO
7 EXISTING CONTRACTS BETWEEN AN INSURER AND A PHYSICIAN, PHYSICIANS MAY
8 OFFSET SUCH INSURER OVERPAYMENT CLAIMS WITH INSTANCES OF DOCUMENTED
9 UNDERPAYMENT DURING THE PERIOD IN QUESTION.

10 (4) For the purposes of this subsection the term "health care provid-
11 er" shall mean an entity licensed or certified pursuant to article twen-
12 ty-eight, thirty-six or forty of the public health law, a facility
13 licensed pursuant to article nineteen, thirty-one or thirty-two of the
14 mental hygiene law, or a health care professional licensed, registered
15 or certified pursuant to title eight of the education law.

16 (5) [Nothing in this section shall be deemed to limit a health plan's
17 right to pursue recovery of overpayments that occurred prior to the
18 effective date of this section where the health plan has provided the
19 health care provider with notice of such recovery efforts prior to the
20 effective date of this section.] ALL CLAIMS FOR ALLEGED OVERPAYMENTS
21 SHALL BE BASED ON AUDITS OF MEDICAL RECORDS FOR EACH CLAIM FOR WHICH AN
22 OVERPAYMENT IS ALLEGED AND MAY NOT BE EXTRAPOLATED FROM A SAMPLE OF
23 CLAIMS.

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

26 (7) WHERE THE INSURER HAS CONFIRMED THE ELIGIBILITY OF A PATIENT'S
27 COVERAGE PRIOR TO THE PROVISION OF SERVICES BY A PHYSICIAN WHO IN GOOD
28 FAITH RELIED UPON SUCH INSURER VERIFICATION, INSURER MAY NOT SUBSEQUENT-
29 LY SEEK FINANCIAL RECOVERY FROM A PHYSICIAN FOR SUCH RENDERED SERVICES
30 ON THE GROUNDS THAT THE PATIENT WAS NOT COVERED BY THE INSURER.

31 (8) INSURERS SHALL PAY PHYSICIANS THE AVERAGE SALES PRICE (ASP) FORMU-
32 LA ESTABLISHED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
33 PURSUANT TO SECTION 1847A OF THE SOCIAL SECURITY ACT, FOR THE COST OF
34 ACQUIRING COVERED VACCINES, BIOLOGICALS, AND OTHER INJECTABLE MEDICA-
35 TIONS.

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

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

47 (11) INSURERS THAT SELL HEALTH SAVINGS ACCOUNTS PRODUCTS AS DEFINED IN
48 26 USC 223 SHALL CREATE AND MAINTAIN AN INTERNET WEB SITE CONTAINING THE
49 LISTING OF INDIVIDUAL COSTS OF PARTICULAR MEDICAL SERVICES AND PROCE-
50 DURES INCLUDING USUAL, CUSTOMARY AND REASONABLE CHARGES FOR PHYSICIANS
51 AND HOSPITALS REFERENCING UPDATED CURRENT PROCEDURE TERMINOLOGY (CPT)
52 CODES AND SHALL MAKE AUTOMATED ACCESS TO CURRENT PATIENT HEALTH SAVINGS
53 ACCOUNTS DEDUCTIBLE INFORMATION AVAILABLE TO PHYSICIANS AND PATIENTS.

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