

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

3992--A

2009-2010 Regular Sessions

I N S E N A T E

April 7, 2009

Introduced by Sens. DILAN, DIAZ, HASSELL-THOMPSON, KLEIN, KRUEGER, MONSERRATE, MONTGOMERY, ONORATO, OPPENHEIMER -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to rules relating to the processing of health claims and overpayments to physicians and other health care providers

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

- 1 Section 1. Section 3224-b of the insurance law, as added by chapter
2 551 of the laws of 2006, is amended to read as follows:
3 S 3224-b. Rules relating to the processing of health claims and over-
4 payments to physicians AND OTHER HEALTH CARE PROVIDERS. (a) Processing
5 of health care claims. This subsection is intended to provide uniformity
6 and consistency in the reporting of medical services and procedures as
7 they relate to the processing of health care claims and is not intended
8 to dictate reimbursement policy.
9 (1) DEFINITIONS.
10 (I) For purposes of this section, a "health plan" shall be defined as
11 an insurer that is licensed to write accident and health insurance, or
12 that is licensed pursuant to article forty-three of this chapter or is
13 certified pursuant to article forty-four of the public health law.
14 (II) FOR THE PURPOSES OF THIS SECTION, A "PHYSICIAN" SHALL BE DEFINED
15 AS A PERSON LICENSED OR OTHERWISE AUTHORIZED TO PRACTICE MEDICINE IN
16 THIS STATE PURSUANT TO SECTION SIXTY-FIVE HUNDRED TWENTY-TWO OF THE
17 EDUCATION LAW.
18 (III) FOR THE PURPOSES OF THIS SECTION, A "HEALTH CARE PROVIDER" SHALL
19 BE DEFINED AS ANY OTHER HEALTH CARE PROFESSIONAL OTHER THAN A PHYSICIAN
20 WHO, WHERE APPLICABLE, POSSESSES A CURRENT AND VALID NON-RESTRICTED
21 LICENSE, CERTIFICATE OR REGISTRATION TO PRACTICE IN THIS STATE PURSUANT

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

LBD10072-04-9

1 TO TITLE EIGHT OF THE EDUCATION LAW OR, WHERE NO PROVISION FOR A
2 LICENSE, CERTIFICATE OR REGISTRATION EXISTS, IS CREDENTIALLED BY THE
3 NATIONAL ACCREDITING BODY APPROPRIATE TO THE PROFESSION.

4 (2) Subject to the provisions of paragraph three of this subsection, a
5 health plan shall accept and initiate the processing of all health care
6 claims submitted by a physician OR OTHER HEALTH CARE PROVIDER pursuant
7 to and consistent with the current version of the American medical asso-
8 ciation's current procedural terminology (CPT) codes, reporting guide-
9 lines and conventions and the centers for medicare and medicaid services
10 healthcare common procedure coding system (HCPCS).

11 (3) Nothing in this section shall preclude a health plan from deter-
12 mining that any such claim is not eligible for payment, in full or in
13 part, based on a determination that:

14 (i) the claim is not complete as defined by 11 NYCRR 217;

15 (ii) the service provided is not a covered benefit under the contract
16 or agreement, including but not limited to, a determination that such
17 service is not medically necessary or is experimental or investigation-
18 al;

19 (iii) the insured did not obtain a referral, pre-certification or
20 satisfy any other condition precedent to receive covered benefits from
21 the physician OR OTHER HEALTH CARE PROVIDER;

22 (iv) the covered benefit exceeds the benefit limits of the contract or
23 agreement;

24 (v) the person is not eligible for coverage or is otherwise not
25 compliant with the terms and conditions of his or her contract;

26 (vi) another insurer, corporation or organization is liable for all or
27 part of the claim; or

28 (vii) the plan has a reasonable suspicion of fraud or abuse. In addi-
29 tion, nothing in this section shall be deemed to require a health plan
30 to pay or reimburse a claim, in full or in part, or dictate the amount
31 of a claim to be paid by a health plan to a physician OR OTHER HEALTH
32 CARE PROVIDER.

33 (4) Every health plan shall publish on its provider website and in its
34 provider newsletter the name of the commercially available claims edit-
35 ing software product that the health plan utilizes and any significant
36 edits, as determined by the health plan, added to the claims software
37 product after the effective date of this section, which are made at the
38 request of the health plan. The health plan shall also provide such
39 information upon the written request of a physician OR OTHER HEALTH CARE
40 PROVIDER who is a participating physician OR PARTICIPATING HEALTH CARE
41 PROVIDER in the health plan's provider network.

42 (b) Overpayments to physicians AND OTHER HEALTH CARE PROVIDERS.

43 (1) Other than recovery for duplicate payments, a health plan shall
44 provide thirty days written notice to physicians AND OTHER HEALTH CARE
45 PROVIDERS before engaging in additional overpayment recovery efforts
46 seeking recovery of the overpayment of claims to such physicians AND
47 OTHER HEALTH CARE PROVIDERS. Such notice shall state the patient name,
48 service date, payment amount, proposed adjustment, and a reasonably
49 specific explanation of the proposed adjustment.

50 (2) A health plan shall not initiate overpayment recovery efforts more
51 than twenty-four months after the original payment was received by a
52 physician OR OTHER HEALTH CARE PROVIDER. Provided, however, that no
53 such time limit shall apply to overpayment recovery efforts which are:

54 (i) based on a reasonable belief of fraud or other intentional miscon-
55 duct, or abusive billing,

1 (ii) required by, or initiated at the request of, a self-insured plan,
2 or
3 (iii) required by a state or federal government program.
4 Notwithstanding the aforementioned time limitations, in the event that
5 a physician OR OTHER HEALTH CARE PROVIDER asserts that a health plan has
6 underpaid a claim or claims, the health plan may defend or set off such
7 assertion of underpayment based on overpayments going back in time as
8 far as the claimed underpayment. For purposes of this paragraph,
9 "abusive billing" shall be defined as a billing practice which results
10 in the submission of claims that are not consistent with sound fiscal,
11 business, or medical practices and at such frequency and for such a
12 period of time as to reflect a consistent course of conduct.
13 (3) Nothing in this section shall be deemed to limit an insurer's
14 right to pursue recovery of overpayments that occurred prior to the
15 effective date of this section where the insurer has provided the physi-
16 cian OR OTHER HEALTH CARE PROVIDER with notice of such recovery efforts
17 prior to the effective date of this section.
18 S 2. This act shall take effect January 1, 2010.