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

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2011-2012 Regular Sessions

I N A S S E M B L Y

February 8, 2011

Introduced by M. of A. BING, PAULIN, REILLY, JAFFEE, CASTRO, SCHIMEL, N. RIVERA -- Multi-Sponsored by -- M. of A. COOK, GALEF, MAGEE, M. MILLER, PHEFFER, RAIA, 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] FIFTEEN days of receipt of a claim or bill
16 for 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. A HEALTH CARE PROVIDER WHO SUBMITS CLAIMS ELECTRONICALLY
20 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 AGREED TO BY BOTH
34 PARTIES.
35 (7) INSURERS MAY NOT ASSIGN, LEASE OR CONVEY RIGHTS IN A CONTRACT WITH
36 THE PHYSICIAN TO AN UNRELATED PARTY WITHOUT THE PHYSICIAN'S WRITTEN
37 CONSENT IN EACH INSTANCE OF SUCH PROPOSED ASSIGNMENT, LEASE, OR CONVEY-
38 ANCE UNLESS SUCH ASSIGNMENT, LEASE, OR CONVEYANCE IS TO A PARENT, AFFIL-
39 IATE, OR SUBSIDIARY CORPORATION OR TO A TRANSFEREE OF ALL OR SUBSTAN-
40 TIALLY ALL OF SUCH INSURER'S ASSETS.
41 (8) INSURERS SHALL INDEMNIFY A PHYSICIAN FOR ANY DAMAGES FOR MEDICAL
42 LIABILITY RESULTING FROM THE PHYSICIAN'S COMPLIANCE WITH A PAYER'S
43 UTILIZATION REVIEW DECISIONS.
44 Subject to the provisions of paragraph [three] NINE of this
45 subsection, a health plan shall accept and initiate the processing of
46 all health care claims submitted by a physician pursuant to and consist-
47 ent with the current version of the American medical association's
48 current procedural terminology (CPT) codes, reporting guidelines and
49 conventions and the centers for medicare and medicaid services health-
50 care common procedure coding system (HCPCS) INCLUDING BUNDLED AND UNBUN-
51 DLED SERVICES.
52 [(3)] (9) Nothing in this section shall preclude a health plan from
53 determining that any such claim is not eligible for payment, in full or
54 in part, based on a determination that: (i) the claim is not complete as
55 defined by 11 NYCRR 217; (ii) the service provided is not a covered
56 benefit under the contract or agreement, including but not limited to, a

1 determination that such service is not medically necessary or is exper-
2 imental or investigational; (iii) the insured did not obtain a referral,
3 pre-certification or satisfy any other condition precedent to receive
4 covered benefits from the physician; (iv) the covered benefit exceeds
5 the benefit limits of the contract or agreement; (v) the person is not
6 eligible for coverage or is otherwise not compliant with the terms and
7 conditions of his or her contract; (vi) another insurer, corporation or
8 organization is liable for all or part of the claim; or (vii) the plan
9 has a reasonable suspicion of fraud or abuse. [In addition, nothing in
10 this section shall be deemed to require a health plan to pay or reim-
11 burse a claim, in full or in part, or dictate the amount of a claim to
12 be paid by a health plan to a physician.
13 (4)] (10) Every health plan shall publish on its provider website and
14 in its provider newsletter the name of the commercially available claims
15 editing software product that the health plan utilizes and any signif-
16 icant edits, as determined by the health plan, added to the claims soft-
17 ware product after the effective date of this section, which are made at
18 the request of the health plan. The health plan shall also provide such
19 information upon the written request of a physician who is a participat-
20 ing physician in the health plan's provider network.
21 (b) Overpayments to health care providers. (1) Other than recovery for
22 duplicate payments, a health plan shall provide thirty days written
23 notice to health care providers before engaging in additional overpay-
24 ment recovery efforts seeking recovery of the overpayment of claims to
25 such health care providers. Such notice shall state the patient name,
26 service date, payment amount, proposed adjustment, and a reasonably
27 specific explanation of the proposed adjustment.
28 (2) A health plan shall provide a health care provider with the oppor-
29 tunity to challenge an overpayment recovery, including the sharing of
30 claims information, and shall establish written policies and procedures
31 for health care providers to follow to challenge an overpayment recov-
32 ery. Such challenge shall set forth the specific grounds on which the
33 provider is challenging the overpayment recovery.
34 (3) A health plan shall not initiate overpayment recovery efforts more
35 than twenty-four months after the original payment was received by a
36 health care provider. However, no such time limit shall apply to over-
37 payment recovery efforts that are: (i) based on a reasonable belief of
38 fraud or other intentional misconduct, or abusive billing, (ii) required
39 by, or initiated at the request of, a self-insured plan, or (iii)
40 required or authorized by a state or federal government program or
41 coverage that is provided by this state or a municipality thereof to its
42 respective employees, retirees or members. Notwithstanding the aforemen-
43 tioned time limitations, in the event that a health care provider
44 asserts that a health plan has underpaid a claim or claims, the health
45 plan may defend or set off such assertion of underpayment based on over-
46 payments going back in time as far as the claimed underpayment. For
47 purposes of this paragraph, "abusive billing" shall be defined as a
48 billing practice which results in the submission of claims that are not
49 consistent with A PHYSICIAN'S sound fiscal, business, or medical prac-
50 tices and at such frequency and for such a period of time as to reflect
51 a consistent course of conduct. EVERY INSTANCE OF ALLEGED ABUSIVE BILL-
52 ING SHALL BE SUBSTANTIATED BY A REVIEW OF THE MEDICAL RECORD PERTAINING
53 TO EACH CLAIM FOR WHICH FINANCIAL RECOVERY IS SOUGHT. WHEN THERE IS A
54 DISPUTE BETWEEN AN INSURER AND PHYSICIAN OVER WHETHER OR NOT A CLAIM
55 CONSTITUTES ABUSIVE BILLING, IT SHALL BE REFERRED TO AND RESOLVED BY THE
56 INDEPENDENT DISPUTE RESOLUTION REVIEW BOARD AS SPECIFIED IN PARAGRAPH

NINE 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.

(4) For the purposes of this subsection the term "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen, thirty-one or thirty-two of the mental hygiene law, or a health care professional licensed, registered or certified pursuant to title eight of the education law.

(5) [Nothing in this section shall be deemed to limit a health plan's right to pursue recovery of overpayments that occurred prior to the effective date of this section where the health plan has provided the health care provider 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.

(6) INSURERS MAY NOT RECOUP CLAIMED OVERPAYMENTS BY OFFSETTING REIMBURSEMENT OWED FOR SERVICES RENDERED TO OTHER PATIENTS EXCEPT WHERE THERE IS CONSENT BY THE HEALTH CARE PROVIDER.

(7) 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.

(8) INSURERS SHALL NOT REDUCE THE LEVEL OF CPT CODES FOR BILLED COVERED SERVICES WITHOUT FIRST PERFORMING AN AUDIT REVIEW OF ALL THE PERTINENT PATIENT MEDICAL RECORDS.

(9) THE SUPERINTENDENT SHALL ESTABLISH AN INDEPENDENT DISPUTE RESOLUTION REVIEW BOARD CONSISTING OF PHYSICIANS LICENSED TO PRACTICE MEDICINE IN THE STATE OF NEW YORK 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 CPT CODING CONSULTANTS) IN REVIEWING AND DECIDING A BILLING DISPUTE. THIS FEE IS TO BE BORNE BY THE PARTY WHO LOSES THE DISPUTE DECISION.

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.