§ 3224-b. Rules relating to the processing of health claims and overpayments 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.

(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) 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 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 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) 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 health care providers. (1) Other than recovery for duplicate payments, a health plan shall provide thirty days written notice to health care providers before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims to such health care providers. 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 provide a health care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for health care providers to follow to challenge an overpayment recovery. Such challenge shall set forth the specific grounds on which the provider is challenging the overpayment recovery.

(3) A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that 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 or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members. Notwithstanding the aforementioned time limitations, in the event that a health care provider 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.

(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.