



PROVIDER NOTICE

Statutory Changes

Health Plus is required to inform our providers of statutory changes to New York State Insurance Law (INS) and Public Health Law (PHL). The changes are detailed below.

Adverse Reimbursement Change Notice

Effective January 1, 2010

PHL §4406-c has been amended. Health care professionals are to receive written notice from the Managed Care Organization (MCO) at least 90 days prior to an adverse reimbursement change to the provider's contract. If the health care professional objects to this change, they may terminate the contract. Termination requires that written notice be provided to the MCO within 30 days of the date of the notice of change. Termination is effective as of the implementation date of the reimbursement change. An adverse reimbursement change is one that can be expected to "have an adverse impact on the aggregate level of payment" to the professional. A health care professional under this section is one who is licensed, registered, or certified under Title 8 of the New York State Education Law.

Statutory exceptions to the MCO adverse-reimbursement-change notice requirement are as follows:

1. The change is required by law, regulation, applicable regulatory authority, or is required due to changes in fee schedules or payment policies by the State or Federal Government or by the AMA's CPT Codes and Reporting Guidelines.
2. The change is provided for in the contract between the MCO and the provider, or the IPA and the provider, through reference to a specific fee schedule or reimbursement methodology.

Claims Processing Timeframes

Effective January 1, 2010

The timeframe for payment of claims based on electronic versus paper or facsimile submission was added to INS § 3224-a. Claims submitted electronically must be paid within 30 days. Paper or facsimile claims must be paid within 45 days. The 30-day timeframe for requesting additional information or for denying the claim was not changed.

Claims Processing, Coordination of Benefits

Effective January 1, 2010

Under the new INS § 3224-c, the MCO cannot deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless the MCO has a “reasonable basis” to believe that the member has other health insurance coverage that is primary for the claimed benefit. If the MCO requests information from the member regarding other coverage and doesn’t receive it within 45 days, the MCO must adjudicate the claim. The claim cannot be denied on the basis of non-receipt of information about other coverage. This section only addresses the denial of claims due to other insurance. It leaves unchanged the plan’s annual process of determining alternate insurance of its members.

Claims Processing, Overpayment Recovery

Effective January 1, 2010

The process for overpayment recoveries in INS § 3224-b (b) was amended to apply to all health care professionals licensed, registered, or certified under Title 8 of the State Education Law and providers licensed or certified pursuant to PHL Articles 28, 36, or 40 or Mental Hygiene Law Articles 19, 31, and 32. The statute requires that the MCO provides the health care professional or provider with an opportunity to challenge the overpayment recovery.

Claims from a Participating Hospital Associated with a Non-Participating Health Care Provider Claim; and Claims from a Participating Health Care Provider Associated with a Non-Participating Hospital Claim

Effective January 1, 2010

MCOs are prohibited from treating a claim from a network hospital as out-of-network solely on the basis that a non-participating provider treated the member. Likewise, a claim from a participating provider cannot be treated as out-of-network solely because the hospital is not participating with the MCO. Provider in this section means an individual licensed, certified, or registered under Title 8 of the Education Law or comparably licensed, registered, or certified by another state.

Amendments to grievances and claims-payment policies and procedures are required to assure claims are not denied or reduced in instances solely because the service was provided by a

participating provider at a non-participating hospital; or a non-participating provider rendered services to a member at a participating hospital.

Provider External Appeal Rights

Effective January 1, 2010

PHL § 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. Payment for an external appeal was amended to include a provider filing an external appeal of a concurrent adverse determination. A provider is responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of the MCO. An MCO is responsible for the full cost of an appeal that is overturned. The provider and MCO must evenly divide the cost of a concurrent adverse determination that is overturned in-part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the MCO's responsibility. To claim that the appeal of the final adverse determination is made on behalf of the member, the provider must complete the external appeal application and designation. The Superintendent has the authority to confirm the designation or to request additional information from the member. If the member does not respond, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

Provider External Appeals, Hold Harmless

Effective January 1, 2010

PHL was amended to add a new section, § 4917. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent. Members are held harmless in such cases.

Provisional Credentialing

Effective January 1, 2010

The MCO will allow newly-licensed practitioners or practitioners relocating from another state that are joining the in-network group practice to apply for provisional credentialing if the MCO has not credentialed the practitioner within 90 days after receipt of a complete application. Practitioners with provisional credentialing are treated as in-network providers for the provision of covered services, but may not be designated as primary care providers (PCPs).

Provisional credentialing may be granted on or before the ninety-first day of receipt of the complete application and shall last until the final credentialing determination is made.