

11 BILLING AND REIMBURSEMENT

11.1 GENERAL PAYMENT GUIDELINES

When adjudicating claims the Plan applies all applicable federal and state statutes, regulations and agency guidelines, including but not limited to those payment rules set forth in Title 10 of the New York Code of Rules and Regulations.

11.2 CAPITATION

The Plan generally pays PCPs a monthly capitation fee for each Plan member on their panel. PCPs are expected to file a claim each time a member is seen in their office. Claims should be submitted in the approved CMS1500 or UB04 format, dependent on your practice type. Claims can also be submitted electronically using submitter ID# 11325 in the HIPAA compliant 837P or 837I format. These claims serve as encounter data, which is used by the Plan to evaluate quality, identify utilization trends, satisfy New York managed care quality reporting requirements (QARR), and assess primary care practitioner performance.

11.3 FEE-FOR-SERVICE CLAIMS

All specialists and ancillary providers are paid on a fee-for service basis. Reimbursement by the Plan for covered services provided to Plan members is considered payment in full. As such, Providers may not bill Plan members for the difference between the Plan claims payment and your charges (balance billing) except for any applicable co-payments, coinsurance or deductibles.

11.4 CLAIMS SUBMISSION

All claims and primary care encounters must be submitted within 90 days of the date of service due to New York State Department of Health reporting requirements. Claims submitted beyond the 90-day limit will be denied.

It is expected that Plan Providers will submit “clean claims”. A “clean claim” is defined as one that can be processed without obtaining any additional information from the provider who rendered the service or a third party. Clean claims, in essence, have no defect, impropriety (including lack of substantiating documentation), or circumstance requiring special handling that might impact or prevent timely remittance of payment.

Providers must include their National Provider Identifier (NPI) on each claim submission. If you have not obtained a NPI, you can apply through a web-based application process. The web address to the National Plan and Provider Enumeration System (NPPES) is <https://nppes.cms.hhs.gov>.

Providers should submit original claim forms. Submission of black and white copies delays claim-processing time and may be returned as not able to process.

Claim inquiries or appeals of claim denials must occur within 60 days of the original claim payment or appeal.

11.5 ELECTRONIC CLAIM SUBMISSION

The Plan is encouraging all providers to submit their claims electronically. We accept claims from any clearinghouse that can submit to Emdeon (formerly known as WebMD).

TAKE ADVANTAGE OF THE MANY BENEFITS OF ELECTRONIC CLAIM SUBMISSIONS:

- Services submitted electronically process more quickly
- Reduced administrative costs
- Reduce volume of paper in your office
- Reduce timely filing denials
- Optimize reimbursement turnaround time

Emdeon currently accepts claims for the Plan with Submitter ID# 11325.

****For information regarding Emdeon and initial set up, contact Emdeon Client Solutions Support Line at 1-800-845-6592.**

UB04 Submitters

Please submit your 837I file with your NPI numbers in the appropriate locations:

NPI Qualifier: XX

Billing Provider NPI: Loop 2010AA, Segment NM1, Data Element 09

Rendering Provider NPI: Loop 2310B, Segment NM1, Data Element 09

CMS1500 Submitters

Please submit your 837P file with your NPI numbers in the appropriate locations:

NPI Qualifier: XX

Billing Provider NPI: Loop 2010AA, Segment NM1, Data Element 09

Rendering Provider NPI: Loop 2310B, Segment NM1, Data Element 09

Please do not include the provider's title or middle initial in the "Last Name Field". There is an element available for it in the Rendering Provider Name segment (loop 2310B, position 250) – NM107 (Name Suffix).

If you are not sure if you are submitting the correct NPI number or you have any additional questions pertaining to electronic claims submission, please contact **Provider Services**.

For services requiring a referral authorization, please use the online electronic referral online (www.getnhp.com or www.suffolkhealthplan.com) or fax a copy of the paper referral prior to submitting claims to Emdeon to minimize denials for lack of authorization.

For lower claim volume submitters, you may also submit your claims electronically via our web portal. The Plan has partnered with MD On-Line to offer our Participating Providers a FREE solution for submitting your CMS1500 claims to us electronically. With electronic claims submission, you will receive your payment faster thus helping to speed up your cash flow. Once you are registered and signed into our web portal, select “Submit Your Claims Electronically”. You will be brought to the MD On-Line web site where you will need to create an account in order to begin submitting your claims.

This service works whether or not your office has billing software. For offices that do not have billing software simply enter the claim information into the online claim form and submit it to us. If you have billing software this solution works with every billing software, and allows for fast, easy uploading and submission of your batch claims.

11.6 PAPER CLAIM FILING

The Plan utilizes Optical Character Recognition (OCR) equipment to process CMS1500 and UB04 paper claim forms. Using this type of equipment reduces the processing time of claims. However, only legible, red-ink, current versions of these claim forms can be scanned into the OCR equipment.

Following these simple instructions will facilitate the processing of your claims:

- Submit original red-ink, current versions of CMS1500 and UB04 claim forms
- Avoid submitting black and white copies
- Report only six lines of service on a single CMS1500 claim form
- Avoid handwriting claims
- Print data within the allotted field size
- Include your National Provider Identifier (NPI)

You can order CMS1500 claim forms by calling the U.S. Government Printing Office at (202)512-1800 or for smaller quantities you may contact your local office supply vendor that provides the red dropout ink version of the form.

If you use the service of an external agency or vendor for the preparation of your claim forms, please ensure that these instructions are available to them.

All claims and encounter forms must be submitted on a CMS1500 or UB04 form to:

Neighborhood Health Providers
Suffolk Health Plan
PO Box 6008
Hauppauge, NY 11788 – 9007

11.7 SUBMITTING DUPLICATE CLAIMS

Submitting duplicate claims increases processing costs, processing times and potential for errors.

We ask for your cooperation in checking claim status online via the Plan's website, via our IVR (Interactive Voice Recognition) or by contacting our Provider Services Department to obtain claim status of a submission prior to resubmitting a claim.

Remember, claim status can be obtained online via the Plan's website or through the IVR 24 hours a day/7 days a week.

11.8 ANESTHESIA BILLING FREQUENTLY ASKED QUESTIONS

Many anesthesia providers have asked us the following questions regarding the appropriate way to bill the Plan for the provision of anesthesia services.

1. Do you limit reimbursement for obstetrical anesthesia?

Yes. There is a 240- minute cap on labor-and-delivery related epidurals. Medical documentation can be submitted to consider reimbursement for time in which the anesthesiologist was in personal attendance beyond 240-minutes (4 hours).

CPT codes 01967 and 01968 should be billed when a vaginal delivery results in a C-section.

When billing anesthesia services for epidurals during labor, the date of service is the delivery date.

2. What time interval is used to determine time units?

15-minute time intervals are used to determine an anesthesia time unit (i.e. 60 minutes = 4 time units)

Anesthesia time for which the anesthesiologist was in personal attendance will be considered for reimbursement.

3. Do you reimburse base units in addition to time and if so, should the base units be identified on the claim submission?

Anesthesia procedures (CPT 00100-01999) are reimbursed as base plus time units.

Base units are maintained in the claims processing system and should not be included on your claim submission.

4. Do you additionally reimburse for the patient's physical status?

No additional payment is made for physical status modifiers P1 through P6.

5. Do you separately reimburse for CPT codes 99100 or 99140?

No. Procedure codes 99100 (special anesthesia service) and 99140 (emergency anesthesia) are not separately reimbursed.

6. What calculation is used to reimburse general anesthesia services?

The total minutes billed are converted into time units and added to the base unit. This sum is then multiplied by the contracted conversion factor to determine the appropriate reimbursement.

Time in minutes ÷ 15-minutes per time unit = Time Units Sum*

(Time Units Sum + Base units) x Per Unit Conversion Factor

* Rounded to the nearest whole value. For example:

70 minutes ÷ 15 = 4.6 time units (rounded up to 5).

If submit 1-7 minutes time unit value = 0 (round down to nearest whole value).

If submit 8 minutes time value = 1 (round up to nearest whole value).

7. What procedure codes should be utilized?

Bill general anesthesia services using the ASA/CPT codes (00100-01999).

DO NOT bill general anesthesia using surgical CPT codes with anesthesia modifiers. Claims submitted in this manner will be denied to resubmit using anesthesia CPT codes.

All other services (i.e. injections) should be billed with the appropriate CPT code.

8. Should minutes or time units be billed?

Please bill the total time in minutes using qualifier MJ.

Do NOT utilize qualifier UN. Claims submitted using qualifier UN will be interpreted as total minutes and therefore underpaid.

Only the total minutes are to be reported as the days/units (box 24g of CMS-1500) when billing general anesthesia services.

For example:

If anesthesia was administered between 9 a.m. and 10 a.m., box 24g should reflect 60 minutes.

If anesthesia was administered between 12 noon and 2:12 p.m., box 24g should reflect 132 minutes.

9. Where should the start and stop time be placed?

This information can be submitted but is not required for claims processing via EDI.

It is recommended that this information be included on paper claim submissions but is not required.

Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the physician is no longer in personal attendance.

Personal attendance, or time in attendance, is time spent face-to-face with the patient.

Documentation of time in attendance must always be recorded in the patient's record.

If you need additional assistance or have questions not covered above please contact Provider Services.

11.9 VACCINES FOR CHILDREN (VFC) PROGRAM

The New York State Department of Health's Vaccines For Children Program purchases and distributes vaccines for all Medicaid Managed Care enrollees under the age of 19 and all **Child Health Plus (CHP)** enrollees. All Providers who serve our pediatric members must be enrolled in the VFC program to obtain vaccines approved for children free of charge. The Plan does not reimburse for vaccines. If you require assistance in enrolling into the VFC program you may contact:

[Gary Rinaldi](#)

New York State Dept of Health
Immunization Program
Coming Tower Bldg., Room 649
Albany, N.Y. 12237
Phone: 518-473-4437
Fax: 518-473-4222

Or if you are located in New York City you may contact:

[Angel Lapaz](#)

Department of Health
Bureau of Immunization
455 First Ave
New York, N.Y. 10016
Phone: 212-447-2574
Fax: 212-447-3309

Additionally, the Plan is **not required** to pay providers for the cost of vaccine. Therefore, claims submitted for members under age 19 and one of the immunization procedure codes listed in the following page will be denied with a message referencing the VFC program. To order vaccines through the Vaccine For the Vaccines For Children Program please call 1-800-543-7468

VACCINE	FULL NAME OF VACCINE	MANUFACTURER	CPT CODE
DT	Diphtheria Tetanus Toxoid vaccine	SANOFI	90702
DTAP (Tripedia)	Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine	SANOFI	90700
DTAP (Daptacel)	Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine	SANOFI	90700
DTAP (Infanrix)	Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine	GlaxoSmithKline	90700
DTaP-Hep B-IPV (Pediarix)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Hepatitis B and Inactivated poliovirus vaccine	GlaxoSmithKline	90723
DTaP-IPV-Hib (Pentacel)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus, Haemophilus Influenza B vaccine	SANOFI	90698
DTAP/HIB (Trihibit)	Diphtheria, Tetanus Toxoid, Acellular Pertussis Haemophilus Influenza B vaccine	SANOFI	90721
DTaP-IPV (Kinrix)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus vaccine	GlaxoSmithKline	90696
e-IPV	Inactivated poliovirus vaccine	SANOFI	90713
HEPATITIS A PED (Vaqta)	Hepatitis A Pediatric vaccine	MERCK	90633
HEPATITIS A PED (Havrix)	Hepatitis A Pediatric vaccine	GlaxoSmithKline	90634
HEPATITIS B (PED/ADOL) (Engerix B)	Hepatitis B pediatric/adolescent vaccine	GlaxoSmithKline	90744
HEPATITIS B (PED/ADOL) (Recombivax HB)	Hepatitis B pediatric/adolescent vaccine	MERCK	90744
HEPATITIS B -2 dose (11-15 only)	Hepatitis B adult - 2 dose vaccine	MERCK	90743
HEPATITIS A-HEPATITIS B	Hepatitis A and Hepatitis B combo vaccine (Twinrix)	GlaxoSmithKline	90636
HEP B HIB (Comvax) not available until further notice	Hepatitis B and Haemophilus Influenza B vaccine	MERCK	90748
HIB (Pedvax)	Haemophilus B conjugate vaccine	MERCK	90647
HIB (Acthib)	Haemophilus Influenza B vaccine	SANOFI	90648
HIBERIX –BOOSTER ONLY	Haemophilus Influenza B vaccine	GlaxoSmithKline	90648
HPV 4 (for girls and boys)-GARDASIL	Human Papilloma Virus vaccine	MERCK	90649
HPV 2 (for girls)-CERVARIX	Human Papilloma Virus vaccine	GlaxoSmithKline	90650
MENINGOCOCCAL CONJUGATE (Menactra)	Meningococcal Conjugate vaccine	SANOFI	90734
MENINGOCOCCAL CONJUGATE (Menveo)	Meningococcal Conjugate vaccine	NOVARTIS/CHIRON	90734
MMR	Measles, Mumps and Rubella vaccine	MERCK	90707
MMR-V (Proquad) not available until further notice	Measles, Mumps and Rubella and Varicella vaccine	MERCK	90710
PNEUMOCOCCAL (Prevnar 13)	Pneumococcal conjugate vaccine	WYETH AYERST	90670
PNEUMOCOCCAL (2 yr and up)	Pneumococcal polysaccharide vaccine	MERCK	90732
TD (Decavac)	Tetanus Toxoid and Diphtheria vaccine	SANOFI	90718
ROTAVIRUS (Rotateq)	Rotavirus vaccine	MERCK	90680
ROTAVIRUS (Rotarix)	Rotavirus vaccine	GlaxoSmithKline	90681
TDAP (Boostrix)	Tetanus Toxoid and Diphtheria and acellular pertussis vaccine	GlaxoSmithKline	90715
TDAP (Adacel)	Tetanus Toxoid and Diphtheria and acellular pertussis vaccine	SANOFI	90715
VARICELLA (Varivax)	Varicella virus vaccine	MERCK	90716

As of May 2010

11.10 **MEDICAL CLAIM REVIEW**

The Plan conducts ongoing reviews to examine medical claims for consistency and accuracy in billing processes. The goal has always been to be fair and equitable in this endeavor. The Plan continues to utilize globally accepted guidelines including CPT regulations as documented by the AMA, Correct Coding Initiatives (CCI) and Global Surgery Period Guidelines as outlined by the Center for Medicare and Medicaid Services (CMS).

In our ongoing efforts to improve performance in claims processing and payment, we implemented a new claims processing program in September 2007 to enhance our current platform. This will ensure a more thorough and comprehensive review of all claims. We have also conducted an assessment on previously paid claims to ensure coding compliancy. Several areas of our review are based on the following globally accepted coding principles:

- 1) **Global Surgical Principles:** CMS has defined specific time periods when the Evaluation and Management (E/M) services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code. These procedure codes are evaluated based on major and minor service categories with different defined global day allocations for each.
- 2) **Add-On Principles:** Both CPT and CMS define codes that require the presence of a primary procedure code for appropriate coding. These rules follow the direction set forth in the CPT manual that describes Add-on codes as “procedures/services that are always performed, by the same physician” and “are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes.”
- 3) **Assistant Surgeon Principles:** CMS rules based on the need for an assistant surgeon, co-surgeons and team surgeons for all surgical procedures. CMS is the only governing body that continues to evaluate the need for this type of service.
- 4) **CCI- National Correct Coding Initiative:** As defined by CMS:
 - a) **Comprehensive:** These procedure codes have been identified as inappropriate unbundling of comprehensive procedure codes into its component parts (codes).
 - b) **Mutually Exclusive:** These procedures codes are not to be reported together because they are mutually exclusive of each other and cannot occur during the same operative session.

- 5) **Duplicates:** For the following areas: Radiology, Date Range Duplicates, Lifetime Duplicates and E/M Service Range.
- 6) **Unbundled Procedure Principles:** In addition to CCI, there are code pairs that are considered to be a component of another procedure code, filed on the same date of service by the same provider.
- 7) **Evaluation and Management Crosswalk Principles:** Multiple submissions of E/M codes within the same category and/or two different categories, by the same provider on the same date of service.
- 8) **IN – Incidental Procedures:** The Incidental Procedures category of edits identifies procedure codes classified as not payable due to a status of B (bundled) or P (bundled/excluded) in the CMS National Physician Fee Schedule Relative Value File.
- 9) **MN — Medical Necessity Based on Appropriate ICD-9 Codes:** These are Regional and National Medical Necessity guidelines from CMS. Services reported must have the appropriate ICD-9 codes submitted on the claim that demonstrate medical necessity.

The Plan is confident that with your help, the improved claims review process will ensure that appropriate services are delivered and paid correctly. By working together, we can all keep costs reasonable for our customers and make the most efficient use of limited health care dollars.

11.11 FRAUD AND ABUSE MONITORING

The Plan adheres to the following legislation with regards to the monitoring and identification of Fraud and Abuse in billing of services rendered to Plan members:

NYCRR Title 10, Section 98-1.21: Pursuant to Public Health Law section 4414, every MCO that participates in public or government sponsored programs with an enrolled population of 10,000 or more persons in the aggregate in any given year shall develop a plan for the detection, investigation and prevention of fraudulent activities in this state and those fraudulent and abusive activities affecting policies or state or local department of social services contracts issued or issued for delivery in this state.

(1) For the purposes of this section, **fraud** means any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable

federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee or other person(s). A “provider” includes any individual or entity that receives funds in exchange for the provision, or arranging for the provision, of health care services to an MCO enrollee.

(2) For the purposes of this section, **abuse** means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee. It also includes enrollee practices that result in unnecessary cost to the state or federal government, MCO, contractor, subcontractor or provider. For the purposes of this paragraph, *provider* includes any individual or entity that receives funds in exchange for providing, or arranging for the provision, of a service.

The Plan has contracted with OptumInsight (formerly Ingenix) to perform periodic evaluations of providers’ claims to identify billing patterns that are aberrant compared to their peers. If OptumInsight identifies an aberrant pattern of billing, they will request medical records from the provider. The medical records will be reviewed to determine if the documentation supports the procedure(s) billed. If it is determined that the medical records do not support the billing, the Plan may initiate a recovery for the deemed amount of overpayment.

OptumInsight is considered a HIPAA Business Associate who has access to providers and/or members’ Protected Health Information (PHI). Therefore, if you receive a request from OptumInsight for medical records, on behalf of the Plan, please comply with their request. Failure to comply may result in an automatic recovery of payments pertaining to the claims in question.

11.12 NEVER EVENTS

Effective January 1, 2010, Health Plans throughout New York State are required to have procedures in place to address the inpatient claims that report a Never Event.

- There are thirteen (13) Never Events. These Never Events include:
 1. Surgery performed on wrong body part.
 2. Surgery performed on wrong patient.
 3. Wrong surgical procedure done on patient.
 4. Retention of a foreign object in a patient after surgery or other procedure.
 5. Patient disability after medication error.
 6. Patient disability associated with a reaction to ABO incompatible blood or blood products provided by a healthcare facility.
 7. Patient disability associated with the use of contaminated drugs, devices, biologics.

8. Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.
 9. Patient disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
 10. Patient disability associated with an electric shock while being cared for in a healthcare facility.
 11. Any incident in which a line designated for oxygen or other gas is contaminated with a toxic substance.
 12. Patient disability associated with a burn incurred from any source while being cared for in a healthcare facility.
 13. Patient disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
- Never Events 4, 6 and 9 listed above will be monitored administratively in a way similar to the procedure used by CMS.
 - The remaining 10 Never Events will be done by chart review. MedReview will request and review hospital medical charts for the Plan.
 - There is no significant experience across the nation to help in the development of policies and procedures for handling Never Events. Some data is available via NYPORTS.
 - Hospitals must always submit the Present on Admission (POA) indicator on all claims.
 - There are no national standardized codes so for the 10 Events that will be reviewed by MedReview; SDOH has developed three (3) rates codes that will indicate a Never Event occurred. They are:

Rate Code	Description
2590	Hospital will use this code to identify that a Never Event happened that was so severe that the hospital does not expect any payment on the claim.
2591	Never Event occurred and may have impacted DRG. Full or Partial payment is expected. Claim requires MedReview review.
2592	Never Event occurred and may have impacted Per Diem payment. Full or Partial payment is expected. Claim requires MedReview review.

- For rate codes 2591/2592, MedReview will conduct review of the chart. Hospitals will be given 30 days to send MedReview the chart. If chart is not received within this time period claim will be denied for any payment.
- MedReview's charge in reviewing these claims will be to:
 - Determine if the Never Event happened.
 - If the Event did happen did it cause any repercussion such as increase in increased length of stay, increased DRG or was no harm done.
 - Set Reimbursement.
- Once decision is made by MedReview, Hospital will get thirty (30) days to review and appeal.
- The Plan (through) /MedReview will track Never Events by type of event and Hospital.
- Since Never Events affect payment it falls under OMIG's Fraud and Abuse policies and procedures.
- The entire process with chart request to final decision should be handled within 90 days.

Frequently Asked Questions and Answers:

- 1. What is the effect on Prompt Payment Requirements?** Rate code 2590 would be denied with no payment as hospital would not expect to receive payment. For rate codes 2591/2592, hospital will submit an original claim which would get paid then hospital would be expected to submit a second claim with one of these rate codes for claim to be reviewed and adjusted. Since original claim would be paid there is no violation of the Prompt Payment Laws.
- 2. How will the Hospitals be notified?** Hospitals will be notified via meetings with various Hospital Associations, direct communications to Hospitals and Medicaid Update Newsletter.
- 3. Why would a Hospital ever use rate code 2590 and not expect payment on a claim?** Failure to identify these situations could position the facility for being sanctioned for fraud and abuse.
- 4. How can the Events affect payment?**
 - a)Event could change the DRG from a lower cost DRG to a higher cost DRG
 - b)Event could add to a DRG by turning the DRG into DRG with complications
 - c)Event could cause the DRG to become a high cost outlier
- 5. How will Never Events impact professional claims?** It is very possible that professional claims will be affected but this will be looked at a later date.

6. **Are any facilities excluded from the Never Events legislation?** Currently, Nursing Homes are the only facilities excluded both at a Federal and New York State level. However, while excluded by the Federal Government, Critical Access Hospitals and Cancer Hospitals **are included** for New York State.
7. **What should be done in cases where the Hospital will not release the medical record because there is litigation and the Risk Management department of the facility will not release the data?** Hospitals get 30 days to submit the requested chart. Failure to do so will result in the claim being denied.

11.13 ADVERSE REIMBURSEMENT CHANGES

This regulation, part of the Managed Care Bill 2009, went into effect on January 1st 2010 and prohibits plans from making adverse reimbursement changes in physician contracts without 90 days prior notice. The provider may elect to terminate the contract within 30 days of the date of the notice, to take effect upon implementation of the adverse reimbursement change.

This does not apply to reimbursement changes otherwise required by law, regulation or applicable regulatory authority or is required a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency.

This does not apply if the change is expressly provided for under the terms of the contract by inclusion of or references to a specific fee schedule, reimbursement methodology or payment policy indexing mechanism.

11.14 CLAIMS PROCESSING TIMEFRAMES

New York State Insurance Law has been amended to modify the timeframe for payment of claims based on electronic submission versus paper or facsimile submission. As of that date, the Plan must be pay all clean claims submitted electronically within thirty (30) days. Clean Paper or facsimile claims must be paid by the Plan within forty-five (45) days. The thirty (30)-day timeframe for requesting additional information or for denying the claim was not changed.

11.15 COORDINATION OF BENEFITS

New York State Insurance Law has been amended to state that 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 forty-five (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 amended section of the law 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.

11.16 RECOVERY OF AN OVERPAYMENT

The process for overpayment recoveries in the New York State Insurance law has been 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 provide the health care professional or provider with an opportunity to challenge the overpayment recovery.

11.17 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

New York State Insurance Law has been amended to prohibit MCOs from treating a claim from a Plan participating hospital as out-of-network solely on the basis that a non-participating provider treated the member. Likewise, a claim from a Plan participating provider cannot be treated as out-of-network solely because the hospital is not participating with the MCO. The term "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.

11.18 PROVIDER EXTERNAL APPEAL RIGHTS

New York State Public Health Law has been 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.

11.19 PROVIDER EXTERNAL APPEALS, HOLD HARMLESS

The New York State Public Health Law has been amended to add section 4917. This new section states that 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.