



STATE OF NEW YORK  
INSURANCE DEPARTMENT  
ONE COMMERCE PLAZA  
ALBANY, NEW YORK 12257

George E. Pataki  
Governor

Howard Mills  
Superintendent

**Circular Letter No. 23 (2006)**  
**November 27, 2006**

**TO: All Insurers Licensed To Write Accident and Health Insurance In New York State, Article 43 Corporations and Health Maintenance Organizations (HMOs)**

**RE: Chapter 551 of the Laws of 2006**

**STATUTORY REFERENCE: Insurance Law Sections 3224-b and 4803(a) and Public Health Law Section 4406-d(1)**

Chapter 551 of the Laws of 2006 was signed into law on August 19, 2006, impacting claims processing for all accident and health insurers and Article 43 corporations ("insurers") and health maintenance organizations (HMOs), and credentialing procedures for insurers offering a managed care product, as defined in Section 4801(c) of the Insurance Law, and HMOs. This new legislation becomes effective January 1, 2007. The following is a summary of provisions and Department guidance to assist in implementation of and compliance with Chapter 551.

The legislation covers several issues for claims processing between insurers or HMOs and physicians by adding a new Section 3224-b to the Insurance Law. First, all insurers and HMOs are required to accept and initiate the processing of physician claims utilizing the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions and the centers for Medicare and Medicaid services (CMS) health care common procedure coding system (HCPCS). Insurers and HMOs shall accept all such physician claims received after January 1, 2007. However, insurers and HMOs are not limited to utilizing only these coding procedures.

This coding requirement does not prohibit an insurer or HMO from reviewing and making determinations regarding whether these claims are ineligible for payment, in whole or in part, based on: lack of completeness as defined in 11 NYCRR 217 (Regulation 178); lack of benefit coverage; exceeded benefit limit; lack of referral or required preauthorization; lack of medical necessity; experimental or investigational service; member ineligibility or noncompliance with subscriber contract provisions; another entity's liability for all or part of the claim; or the insurer's or HMO's reasonable suspicion of fraud or abuse.

Second, every insurer and HMO is required to indicate on its provider web site and in provider newsletters the name of the commercially available software product, including any significant edits, used by the plan to accept/edit claims. Descriptions of plan edits should be detailed enough to reasonably provide an understanding of the modifications made to the software.

This information must also be provided upon request to any contracted physician. The Department will be reviewing compliance with these requirements during market conduct examinations.

Third, except in the case of recovery of duplicate payments, an insurer or HMO must provide 30 days written notice to

a physician before engaging in any collection of overpayments. This notice must include the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment. Policies and procedures should be developed to comply with this provision and documentation should be retained demonstrating such notice was provided to a physician prior to initiation of collection efforts.

Lastly, Section 3224-b also prohibits an insurer or HMO from initiating overpayment recovery efforts more than 24 months after the original payment was received by the physician. This time limit does not apply in the case of reasonable belief of fraud and abuse, abusive billing (as defined in Section 3224-b), recovery efforts initiated or required by self-insured plans or required by a state or federal government program. An insurer or HMO is not restricted from pursuing overpayments occurring prior to the effective date of this law, January 1, 2007, when notice was provided to the physician before that date.

If a physician asserts underpayment of a claim, the insurer or HMO may defend or offset the assertion by overpayments that were made within the timeframe extending as far back as to the underpayment in question. If the underpayment is confirmed, the insurer or HMO may lessen or balance the amount owed to the provider by identifying an amount the insurer or HMO overpaid to the provider from the time of the underpayment to the present. However, the insurer or HMO may not collect overpayments in excess of the physician underpayment, unless the overpayment occurred within the last 24 months or an exception applies as described above.

Chapter 551 also amends Section 4406-d(1) of the Public Health Law with respect to HMOs and Section 4803(a) of the Insurance Law with respect to insurers offering a managed care product. In addition to providing written application and minimum qualification requirements for network participation to health care professionals upon request, an HMO or insurer offering a managed care product, as defined by Section 4801(c) of the Insurance Law, shall respond to a health care professional's application within 90 days. When a completed application is received, the HMO or insurer offering a managed care product must respond informing the applicant whether the applicant is accepted and credentialed to participate in the network or that more time is needed to review the application or complete the credentialing process due to information not forthcoming from a third party or other extenuating circumstance. The HMO or insurer offering a managed care product must make every reasonable effort to resolve the delay as soon as possible.

If an incomplete application is received or if the HMO or insurer offering a managed care product is not currently accepting additional providers of the applicant's type, the HMO or insurer offering a managed care product should respond to the applicant with such notice as soon as possible but no later than 90 days from receipt of the application.

Any questions on this Circular Letter may be directed to:

Lisette Johnson  
Health Bureau  
New York Insurance Department  
One Commerce Plaza  
Albany, New York 12257

Or by e-mail to [Lisette Johnson](mailto:Lisette.Johnson)

Very Truly Yours,

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Charles Rapacciuolo  
Assistant Deputy Superintendent & Chief,  
Health Bureau