



STATE OF NEW YORK
INSURANCE DEPARTMENT
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Circular Letter No. 17 (2010)
October 25, 2010

TO: All Insurers Licensed to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations (HMOs) (collectively, “insurers”)

RE: Evaluation and Management Current Procedural Terminology Codes

STATUTORY REFERENCE: N.Y. Ins. Law § 3224-b and Articles 48 and 49; N.Y. Pub. Health Law § 4408-a and Article 49

The purpose of this Circular Letter is to remind insurers that an insurer:

1. Must accept and initiate processing of all health care claims submitted by psychiatrists or other physicians pursuant to, and consistent with, the current version of the American Medical Association (AMA) current procedural terminology (CPT) codes, reporting guidelines and conventions, including Evaluation and Management (E/M) CPT codes; and
2. May not limit the types of CPT codes that it accepts from psychiatrists or other physicians to the codes specifically designated as “psychiatric” in the AMA’s CPT codes, reporting guidelines and conventions.

It has come to the Insurance Department’s attention that certain insurers refuse to accept and initiate the processing of E/M CPT codes when psychiatrists or other physicians submit those codes for the treatment of a mental, nervous or emotional disorder or ailment.

Although an insurer is not required to contract with a psychiatrist or other physician for all services that the psychiatrist or other physician is licensed to perform, Insurance Law § 3224-b prohibits an insurer from refusing to accept and initiate processing of E/M CPT codes from psychiatrists. Specifically, Insurance Law § 3224-b(a)(2) provides that an insurer “shall accept and initiate 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...” Because psychiatrists are physicians, an insurer must accept and initiate processing of all health care claims submitted by a psychiatrist pursuant to, and consistent with, the current version of the AMA’s CPT codes, reporting guidelines and conventions. Accordingly, an insurer that refuses to

accept or initiate processing of an E/M CPT code submitted by a psychiatrist violates Insurance Law § 3224-b(a)(2). Likewise, an insurer may not limit the types of CPT codes that it accepts from a psychiatrist to the codes specifically designated as “psychiatric” in the AMA’s CPT codes, reporting guidelines and conventions. In addition to accepting and initiating the processing of E/M CPT codes from psychiatrists, an insurer must accept and initiate the processing of such codes from any physician who submits a claim using an E/M CPT code for treatment of a mental, nervous or emotional disorder or ailment. These requirements apply whether the insurer’s coverage is primary or secondary.

Further, there is nothing in Insurance Law § 3224-b that permits an insurer and psychiatrist or other physician to agree to waive the requirements contained in that section.

Although Insurance Law § 3224-b(a)(2) requires an insurer to accept and initiate processing of E/M CPT codes, it does not require an insurer to reimburse for a claim or dictate the amount that the insurer must pay a psychiatrist or other physician for a claim. Specifically, Insurance Law § 3224-b(a)(3) provides that:

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.

Further, after an insurer accepts and initiates processing of E/M CPT codes, the insurer may review the claim so long as it conducts its review in accordance with Articles 48 and 49 of the Insurance Law, which apply to managed care health insurance contracts and utilization review and external appeal, respectively, Public Health Law § 4408-a, as added by Chapter 705 of the Laws of 1996, which applies to HMO grievance procedures, and Article 49 of the Public Health Law, which applies to HMO utilization review and external appeal.

Please direct any questions regarding this Circular Letter to Thomas Fusco, Supervising Insurance Attorney, Health Bureau, New York Insurance Department, Walter J. Mahoney Office Building, 65 Court Street, Room 7, Buffalo, New York 14202, or by e-mail to tfusco@ins.state.ny.us.

Very truly yours,

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