

OASAS
Insurance/Managed Care Panel Discussion
Overview of Recent Legislative Changes

2009 Managed Care Bill – Chapter 237 of 2009

- Timely filing of claims is 120 days from date of service
- Adverse reimbursement changes to a provider contract.
 - 90 day advance written notice required
 - Within 30 days of notice provider may terminate contract with written notice. Termination effective upon implementation date of the change.
 - Notice provision shall not apply where the change is required by law or is the result of changes in payment policies by a government agency or CPT guidelines, or where the change is expressly provided for under the terms of the contract.
- HMO look-a like – Requires insurers that issue any comprehensive policy that utilizes a network or providers and is not a managed care plan to:
 - Establish and maintain a grievance procedure,
 - Provide access to specialty care through a standing referral, if a referral is required under the contract, and
 - Provide access to transitional care.
- Amends the Prompt Pay Law to:
 - Specifically require Muni-Coops to comply
 - Require claims submitted via the internet or electronic mail to be paid within 30 days
 - Establishes a “safe harbor” from fines found during an investigation, examination, audit or inquiry. Does not apply to violations found during the process of investigating a complaint.
- Coordination of Benefits
 - Prohibits the denial of a claim, in whole or in part, on the basis another is liable unless there is a reasonable basis that another insurer is primary,
 - Permits insurers to send COB questionnaires but prohibits the denial of a claim on the sole basis that the questionnaire was not returned.
- Overpayment recovery requirements were extended to facilities. Previously applied only to physician claims.
- No contract that utilizes a participating network of providers shall provide that services of a participating hospital be covered as out-of-network solely on the basis that the provider admitting or render the services is non-participating.
- Provisional Provider Credentialing – permits the provisional credentialing of a newly licensed provider or a provider who did not previously practice in this state if they join a group practice in which all other providers participate with the insurer.
 - An application for credentialing must have been submitted and it is neither approved nor denied in 90 days.

- Changes to Article 49 (Utilization Review)
 - Treatment for a rare disease is now eligible for external appeal,
 - Requests for home health care services following an inpatient hospital admission must be made within one business day of receipt of the necessary information UNLESS the request is made one day before a weekend or holiday. In those cases the decision must be made within 72 hours and the services provided while the UR determination is pending shall not be denied on the basis of medical necessity or lack of prior authorization.
 - Provides for an expedited internal appeal for home health care services.
 - Providers now have their own right to request an external appeal on denials based on concurrent review.
 - “Loser pays”
 - Patient cannot be billed if the denial is upheld.

“Age 29 law”

- permits young adults to continue or obtain coverage under a parent’s policy through the age of 29.

NYS Continuation extension to 36 months

- Amends state continuation coverage (“mini-COBRA”) making it available for a total of 36 months.

Federal Parity

- Does not mandate mental health or substance abuse coverage. The law simply requires parity when an employer chooses to provide such coverage.
- Does not allow:
 - either more restrictive; or
 - separate financial requirements for mental health and substance abuse disorder coverage that is more restrictive than the medical/surgical financial requirements.
- Applies to large groups with 51 or more employees
- The law also requires out of network coverage for mental health and substance abuse if there is out of network coverage for medical/surgical coverage.