OASAS Panel Discussion

Albany NY
May 17, 2010
12:00 – 3:00 p.m.

New York City
June 1, 2010
1:00 – 4:00 p.m.

1. Feedback on the Provider Survey
   a. What information is necessary to investigate a denial?

2. Overview of Recent Legislative Changes
   a. See attached Summary of Changes and Grid of Specific References.
   b. What coverage does DOI and DOH have jurisdiction over?
      i. We are able to act only as the legislature has given us authority:
         1. Insurers and MCOs licensed by State agencies. Ability to
            address vendor action is typically through the licensed
            insurer.
         2. Products not directly overseen by federal government
            programs (ie, Medicare Advantage run by CMS).
         3. Issues that are addressed in State statute (or Medicaid
            managed care/Family Health Plus (MMC/FHP) Model
            Contract)
      ii. DOI and DOH oversee insurers/MCOs
         1. Conduct periodic surveys and examinations to ensure
            operational compliance with licensing requirements and
            statutory mandates.
         2. Review complaints to determine whether the licensed entity
            acted in accordance with law. (This may not resolve all
            payment disputes, particularly contract issues that are not
            addressed in statute).

3. Understanding the Precertification Process and Avoiding Common Pitfalls
   a. Article 49 of the New York Insurance Law and Public Health Law
      i. Title I – Utilization Review, authorizations and appeals
         1. Important to distinguish between enrollee rights and
            provider rights. Provider can act as enrollee designee.
            Most provider rights are defined in the provider contract,
            not statute.
         2. Definitions
            a. Utilization Review (UR) is the review to determine
               whether services requested or already provided are
               medically necessary.
b. “Medical necessity” is not defined in Law; however it may be in the subscriber contract. “Medically Necessary” is defined in the MMC/FHP contract as: health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

c. Clinical standards are guidelines and standards set forth in the UR plan by the UR agent. No minimum standards or guidelines are set forth in the law. Clinical criteria for a specific service must be disclosed by a MCO or insurer upon written request by enrollee or prospective enrollee.

d. A “clinical peer reviewer” for Title I is defined as: a physician with a current, non-restricted license to practice medicine or a health care professional with a current license in the same profession as a provider who would normally oversee the services or treatment under review.

3. Initial adverse determination
   a. Required time frames for determination and notice content requirements are described in Law for preauthorization, concurrent, and retrospective utilization review.
   b. Timeframes differ for Medicaid products or for commercial product subject to US DOL regulations.
   c. Law requires that appropriate UR personnel are reasonably accessible by a toll-free telephone. Also requires that messages be returned not less than one business day after the date the call was received.
   d. Failure to meet the time for rendering a decision is considered denial subject to appeal.
   e. Reconsideration is available if the provider was not consulted prior to denial. Response required in 1 business day except for retrospective review.
   f. The specific clinical criteria for the denial must be provided upon request. Knowing the criteria the plan is using can help with understanding why plan is asking for certain information and later on, with billing.

4. First level of internal appeal
   a. An insured, their designee and in connection with a concurrent or retrospective denial, a health care provider, may appeal an adverse determination.
   b. Time frame to file must be at least 45 days from the Initial adverse determination.
c. Time frame for determinations and notice requirements in statute for expedited and standard appeals.

d. Times differ for Medicaid and group coverage (US DOL)

e. A Final Adverse Determination is issued if the denial is upheld.

f. Failure to render a decision on time is considered a reversal of the denial.

5. Law provides that Utilization review shall not be conducted more frequently than is reasonably required to assess whether health care services under review are medically necessary. Insurance companies and UR agents shall not routinely request copies of medical records of all patients reviewed. During prospective or concurrent review records shall only be required when necessary to verify the service is medically necessary. A UR agent may request partial or complete medical records for retrospective review. MCOs can request records at anytime are not limited as above.

ii. Title II – External Appeal Process

a. An insured, their designee and in connection with a concurrent or retrospective denial, a health care provider, may appeal a final adverse determination.

b. A request for an external appeal must be initiated within 45 days of receipt of the Final Adverse Determination.

c. A “clinical peer reviewer” for Title II is defined as a physician with a current non-restricted license, who is board certified or board eligible (where applicable), has been practicing in such specialty for at least five years and is knowledgeable about the service or treatment under review.

d. There is a process for expedited and standard external appeals.

e. The Law provides that the external appeal agent shall consider the clinical standards of the plan, information concerning the patient, the attending physician’s recommendation, applicable and generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations.

f. The decision is binding on the plan and the insured, and is admissible in any court proceeding.
iii. Keep in mind
1. Just because prior authorization was obtained doesn’t mean provider will be paid by insurer/MCO. Service is still subject to coverage requirements of plan (NYIL § 3238):
   a. coverage on date on service (member may be retro disenrolled)
   b. benefit limits
   c. fraud and abuse
   d. diagnosis/code match
   e. location of service
   f. MMC/FHP may have payment limits, DRGs rules may differ in provider contract
   g. Billing policy and procedures, ie timely filing
   h. Pre-existing condition
2. Also 10 NYCRR 98-1.13(n) applies to MCOs only
   a. Can’t reverse preauthorization on retrospective review unless
      i. Information on retrospective is different from what was presented for preauthorization review, and
      ii. Information existed at time of authorization, and
      iii. MCO was not aware of information at time of authorization, and
      iv. Had the MCO known about the information, the service would not have been approved.
3. Some denials are appropriate. Reimbursement is made according to rules of coverage.
4. Report delays in plan responses, unavailability of UR managers, phone problems, failure to provide reconsideration, and other operating issues to the appropriate licensing agency.
5. Filing external appeals/complaints allows the State to trend and identify overarching issues.

4. What to do when claims do not get paid?
   a. Prompt Pay Law
      i. Requires that claims be processed within specific time frames.
         1. 45 days to pay paper claims, or
         2. 30 days to pay electronic claims, or
         3. 30 days to request additional information
            a. The request must be in writing
            b. The company must request ALL necessary information
         4. 30 days to deny a claim.
ii. Interest accrues on any claim not paid within the timeframes indicated above. The interest rate is 12% simple interest. Any earned interest of less than $2 per claim does not have to be paid.

iii. Failure to deny timely does NOT create a liability to pay the claim.

iv. Under payments are considered to be a prompt pay violation.

b. Pre-existing conditions

i. Is any condition where treatment was recommended or received within the 6 months prior to the enrollment in the new coverage.

ii. Insurers & HMOs can impose a waiting period on pre-existing conditions for up to 12 months.

iii. If the member had prior coverage with a gap of 63 days or less between the coverage, the time that the member had prior insurance will be credited towards the waiting period.

c. Contractual denials

i. Member contract
   1. May contain policy limits or requirements for pre-certification.
   2. Providers are not a party to the member contract and thus may not know the requirements or limits.

ii. Provider contract or provider manual
   1. Will explain actions providers must take for reimbursement, such as pre-certification requirements.
   2. May also include other useful information such as what services the plan has credentialed the provider to perform. This may differ from those services the provider is licensed to perform.
   3. Will explain timely filing requirements and information on how to appeal denials.

d. Miscellaneous Issues

i. Blue Cross 12 pass through visits – not required by law and thus the insurer can change this at any time.

ii. Coding issues
   1. Diagnosis – ICD9 vs. DSMV – this should be addressed in the provider’s participation agreement with the plan.
   2. Inconsistent diagnosis/procedure code – verify that the 2 codes are compatible.
   3. Invalid diagnosis code
   4. The Law does not contain many references to the use of codes, CPT or diagnosis. Insurers are only required to accept and initiate claims processing based on CPT or HCPCS codes. Once claim processing is initiated the insurer can deviate from those guidelines.

iii. Previously processed claims – do not resubmit the claims as if it is a new service, rather the previous processing of the claim must be appealed.

iv. Provider contracts
1. Insurers are permitted to renegotiate contract terms.
2. Fees and reimbursement methodologies are between the parties.
   a. State reviews payment methodologies in MCO contracts where there is a certain level of risk transferred to ensure provider solvency. However, we do not affirm the reasonableness of the payments agreed to by the parties of the agreement.
3. Insurers must provide 90 days advance notice before implementing an adverse reimbursement change. Providers will have the options of terminating their participation agreement if they don’t agree.

v. Overpayment recovery efforts
   1. Insurers can go back no more than 2 years to recover overpayments UNLESS there is a suspicion of fraud or abusive billing.
   2. 30 day advance written notice must be provided before engaging in take back efforts. Notice is claim specific.
   3. No prohibition to removing overpayment recovery language in a provider contract.

5. Conclusion
   a. Where and how to file a complaint – See reference sheet
   b. May also write to:
      New York State Department of Insurance
      Consumer Services Bureau
      One Commerce Plaza
      Albany, New York 12257

      OR

      New York State Department of Health
      Complaint/UR Unit
      Bureau of Managed Care Certification and Surveillance
      Corning Tower Room 1911
      Albany, New York 12237