AmeriChoice by UnitedHealthcare of New York
Supplement to Provider Administrative Guide aka Provider Manual
NYSDOH Chapter 237 of the Laws of 2009

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Chapter 237 of the Laws of 2009 was enacted July 2009 and amended current statues relating to claims processing; credentialing procedures; utilization review and external appeal procedures; and specific requirements when modifying reimbursement arrangements in provider contracts. The following is a summary of the impact of this legislation.

Adverse Reimbursement Change

Effective January 1, 2010, AmeriChoice health care professionals will receive written notice from the health plan at least 90 days prior to an adverse reimbursement change to the provider's contract. If a provider objects to the change that is the subject of the notice by AmeriChoice, the provider may, within thirty days of the date of notice, give written notice to the health plan to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that "could reasonable be expected to have an adverse impact on the aggregate level of payment to a health care professional." A health care professional under this section is one who is licensed, registered or certified under Title 8 of the New York Education Law.

Claims Processing Timeframes

Effective January 1, 2010, claims submitted electronically must be paid within 30 days and paper or facsimile claim submissions must be paid within 45 days. The 30 day timeframe for requesting additional information or for denying the claim was not changed.

Coordination of Benefits

Effective January 1, 2010, AmeriChoice will not deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless the health plan has a "reasonable basis" to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if AmeriChoice requests information from the member regarding other coverage, and does not receive the information within 45 days; the health plan will adjudicate the claim. However, the claim will not be denied on the basis of non-receipt of information about other coverage.

Timeframe for Provider Claims Submission

Effective for dates of service on or after April 1, 2010, providers must initially submit claims within 120 days after the date of the service to be valid, unless a timeframe more favorable to the provider was agreed to by the provider and AmeriChoice, or a different timeframe is required by law.

The law further permits a reconsideration of a participating provider's late claim submission denied exclusively because it was untimely. AmeriChoice will pay the claim if the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions. However, AmeriChoice may reduce the reimbursement of a claim by up to 25 percent. The right to reconsideration shall not apply to a claim submitted 365 days after the service and in such cases AmeriChoice may deny the claim in full.

Definition of Unusual Occurrence: Examples of an unusual occurrence may include but is not limited to: An act of nature, a computer crash/failure, provider unable to access records due to fire or other type of destruction to an office/equipment, provider has transitioned to a new billing system or service. Provider was called to active military duty, etc. This type of reconsideration shall be handled on a case by case basis.

Overpayment Recovery
Effective January 1, 2010, the health plan must provide health care professionals or providers with an opportunity to challenge the overpayment recovery.

Claims from a Participating Hospital Association with a Non-Participating Health care Provider Claim; and Claims from a Participating Health Care Provider Associated with a Non-Participating Hospital Claim
Effective January 1, 2010, AmeriChoice will treat a claim from a network hospital as out-of-network solely on the basis that a non-participating health care provided treated the member. Likewise, a claim from a participating health care provider will be treated as out-of-network solely because the hospital is non-participating with AmeriChoice.

Credentialing
A newly licensed health care professional or health care professional relocating from another state, who is joining a group practice of in network providers, can be considered a "provisionally" credentialed provided on the 91st day after submission of a complete application to AmeriChoice, if the health plan does not approve or decline the application within 90 days. During the provisional period the health care professional is considered an in-network provider for the provision of covered services to members, but may not act as a primary care provider.

If the application is ultimately denied, the provider will revert back to non-participating status. The group practice wishing to include the newly licenses or relocated health care professional must agree to refund any payments made by AmeriChoice for in-network services delivered by the provisionally credentialed provider that exceed any out-of-network benefits. In addition, the provider group must agree to hold the member harmless for payment of any services denied during the provisional period except for collection of co-payments that would have been payable had the member received services from an in-network provider.

This stipulation became effective on October 1, 2009. AmeriChoice is actively working to ensure that the appropriate procedures are in place to comply with this requirement.

Health Care Provider External Appeal Rights (effective January 2010)
Public Health Law §4914 was recently amended to extend external appeal rights to providers in connection with concurrent adverse determinations. Payment for an external appeal at PHL 4914 was amended to include a health care provider's responsibility if filing an external appeal of a concurrent adverse determination. A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of the Managed Care Organization (MCO); an MCO is responsible for the full cost of an appeal that is overturned; and 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 responsibility of the MCO. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal and the designation. The Superintendent has the authority to confirm the designation or to request additional information from the member.

Where the member has not responded, 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.

Alternative Dispute Resolution
A facility licensed under Article 28 of the Public Health Law and the MCO may agree to alternative dispute resolution (ADR) in lieu of an external appeal under PHL §4906 (2). This provision does not impact a member's external appeal rights or right of the member to establish the provider as their designee and if applicable will be communicated in the notice with an initial adverse determination.

New Section of PHL Holds the Member Harmless
Additionally, Public Health Law was amended to add a new section §4917. 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 an external appeal agent.

Alternative Dispute Resolution
A facility licensed under Article 28 of the Public Health Law and the health plan may agree to alternative dispute resolution (ADR) in lieu of an external appeal. This provision does not impact a member's external appeal rights or right of the member to establish the provider as their designee.

Hold Harmless
A provider requesting an external appeal if 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.

External Appeal Rare Disease Treatment (effective January 2010)
Public Health Law 49 was recently amended. As a result, the right to appeal a rare disease treatment determination is now allowed through an external appeal. The definitions of rare disease treatment is found at PHL §4900(7-g); and the established external appeal right for a final adverse determination involving a rare disease treatment was added to Section 4910. Notices of final adverse determinations issued by the Health Plan include the revised standard description and application form.

Home Health Care Determinations Following An Inpatient Admission (effective January 2010)
Subdivision 3 of PHL §4903 was amended to change the timeframe for utilization review determinations of home health care (HHC) services following an inpatient hospital admission. The Managed Care Organization (MCO) must provide notice of its determination within one business day of receipt of the necessary information or, if the day after the request for services falls on a weekend or holiday within 72 hours or receipt of necessary information. However, if a request for home health care services and all necessary information is provided to the MCO prior to a member's inpatient hospital discharge, an MCO cannot deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the UR determination is pending. There may however, be other reasons for denying the service such as exhaustion of a benefit.

An appeal of a denial for home health services following a discharge from a hospital admission must be treated as an expedited appeal under PHL §4904(2).

For the purposes of the PHL section, the term inpatient hospital admission is limited to services provided to a member in a general hospital that provides inpatient care. This may include inpatient services in an Article 28 rehabilitation facility.