VNS CHOICE Notice to Providers Concerning
New York State Regulatory Changes

Applies to Providers of our VNS CHOICE Managed Long Term Care (MLTC) and VNS CHOICE MLTC Plus Members

The New York State Insurance Law and Public Health Law were recently changed. This notice is designed to update you regarding those changes which affect VNS CHOICE and its providers. Unless otherwise stated, all these changes are effective as of January 1, 2010. If you have any questions regarding these updates, please contact Provider Services at 1-866-783-0222.

**Adverse Reimbursement Change**
Public Health Law § 4406-c requires that Managed Care Organizations (MCO) such as VNS CHOICE provide health care professionals with written notice at least 90 days prior to an adverse reimbursement change to the provider’s contract. If the health care professional objects to the change that is the subject of the notice by the MCO, the health care professional may, within thirty days of the date of the notice, give written notice to the MCO to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that “could reasonably 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 State Education Law. There is no private right of action for a health care professional relative to this provision.

**Claims Processing Timeframes**
The timeframe for payment of claims based on electronic versus paper or facsimile submission was added to INS § 3224. Claims submitted electronically to a MCO must be paid within thirty (30) days and paper or facsimile claim submissions must be paid within forty-five (45) days. The thirty (30) day timeframe for requesting additional information or for denying the claim was not changed.

New Subsection (h) of INS § 3224-a permits a reconsideration of a participating provider’s late claim submission denied exclusively because it was untimely. Where the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions the MCO must pay the claim. However, the MCO may reduce the reimbursement of a claim by up to twenty-five percent of the amount that would have been paid had the claim been submitted in a timely manner. Nothing precludes an MCO and a provider from agreeing to a reduction of less than twenty-five percent. The right to reconsideration shall not apply to a claim submitted 365 days after the service and in such cases the MCO may deny the claim in full.

**Coordination of Benefits**
Under the new INS § 3224 (a), an MCO like VNS CHOICE cannot deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless the MCO has a “reasonable basis” to believe that the member has other health insurance coverage that is
primary for the claimed benefit. In addition, if the MCO requests information from the member regarding other coverage, and does not receive the information within forty-five (45) days, the MCO must adjudicate the claim. However, the claim cannot be denied on the basis of non-receipt of information about other coverage.

**Overpayment Recovery**

The process for overpayment recoveries in INS § 3224 (b) was amended to apply to all health care professionals licensed, registered, or certified under Title 8 of the State Education Law, and providers licensed or certified pursuant to PHL Articles 28, 36 or 40 or Mental Hygiene Law Articles, 19, 31 and 32. The statute requires that MCOs provide the health care professional or provider with an opportunity to challenge the overpayment recovery.

**Claims from a Participating Hospital Associated with a Non-Participating Health Care Provider Claim; and Claims from a Participating Health Care Provider Associated with a Non-Participating Hospital Claim**

MCOs are prohibited from treating a claim from a network hospital as out-of-network solely on the basis that a nonparticipating health care provider treated the member. Likewise, a claim from a participating health care provider cannot be treated as out-of-network solely because the hospital is non-participating with the MCO. Health care provider in this section means an individual licensed, certified or registered under Title 8 of the Education Law or comparably licensed, registered or certified by another state.

**Provider External Appeal Rights**

Public Health Law § 4914 was 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 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 MCO; a 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 application 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 time frame will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

Health care providers may request an external appeal on their own behalf to obtain payment when a health plan makes a concurrent or retrospective adverse determination denying health care services as not medically necessary, experimental / investigational, a clinical trial or a rare disease treatment. To request an external appeal, providers should review the External Appeals Instructions and complete the New York State External Appeal Application http://www.ins.state.ny.us/extapp/extappqa.htm
**Provider Provisional Credentialing** (effective October 1, 2009)

Public Health Law § 4406-d (1) was amended to specify the application processing criteria for credentialing newly licensed health care professionals (HCP) or HCPs relocating from another state, who are joining a group practice of in-network providers. A HCP joining a group practice can be considered a "provisionally" credentialed provider on the ninety first day after submitting a complete application to an MCO, if the MCO does not approve or decline the application within ninety days. This status will continue until the MCO either credentials the provider or declines the application. During this provisional period the HCP is considered an in-network provider for the provision of covered services to members, but may not act as a primary care provider (PCP).

The law further states that if the application is ultimately denied, the provider will revert back to non-participating status. The group practice wishing to include the newly licensed or relocated HCP must agree to refund any payments made by the MCO for in-network services delivered by the provisionally credentialed HCP that exceed any out-of-network benefit. In addition, the provider group must agree to hold the member harmless from 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.