



## What We Did in 2006

NorMet Advocacy this past legislative session resulted in the passage of a law that addressed three insurer “market conduct” issues that were especially significant to physicians. Effective January 1, 2007, this law requires health insurers licensed in New York State to abide by:

### *Standardized Coding*

- **What was:** The Center for Medicare and Medicaid Services (CMS) created standard sets of rules such as Common Procedure Types (CPT) and the National Correct Coding Initiative (CCI). CPT codes and modifiers are designed to work together to inform a claims processor what service(s) were performed and how they are to be reimbursed. While insurance companies use these codes for claims processing, they do not honor all the rules of CPT or CCI. CCI is the set of rules that keep physicians from over-billing for services that should not be billed separately (i.e. bundled). For example, CCI prevents a doctor from being paid for both CPT codes 42820 and 42825. The first code is for two procedures performed at the same time (tonsillectomy and adenoidectomy), and the second code is for a tonsillectomy alone. Therefore, the second code should not be paid because it is a component of the first code. This type of national claims edits (as used by Medicare) prevents abusive billing. All insurance carriers currently use some variation of CCI-type edits. The problem is that the variations are not universal, which therefore requires the physician to know too many HMO-specific coding rules, confusing and delaying the billing and payment processes.
- **What is, as of January 1, 2007:** Insurers must adhere to nationally accepted American Medical Association CPT coding rather than developing individual codes per insurer that confuse physicians and hospitals and delay or deny patient care.

### *Expedited Credentialing*

- **What was:** Credentialing of new providers into plans takes an excessively long time (sometimes in excess of 18 months) so new providers cannot bill for patients who belong to a particular plan until this process is completed. By contrast, Medicare credentials within two months, and then retroactively pays physicians for any service performed during the credentialing determination period.
- **What is, as of January 1, 2007:** Insurers must notify physicians and other health care providers who apply for in-network credentialing of their status within 90 days of receipt of a complete application.

### *Limited Takebacks*

- **What was:** Insurers could demand refunds from physicians for up to 7 years. This put undue administrative burden and cost on physicians, not only in terms of digging through archives to locate originating data, but also increasing the potential for bad debt. For example, if the refund request is because the insurance company had paid something that the patient should have paid, the likelihood of the physician being able to successfully recover those funds from the patient after 60 days is minimal. If the insurance company claims they were not responsible for those dates of service due to Coordination of Benefits (COB) or enrollment issues, it is often too late for the physician to submit claims to the next carrier due to their timely filing deadlines.
- **What is, as of January 1, 2007:** Insurers must request refunds from physicians for services approved and performed within two years of the insurer providing payment.