Attention Atlantis Health Plan Providers:

This notice contains important information regarding recent changes to New York State Public Health and Insurance Laws. Please review these changes carefully as your Provider Manual and Atlantis Policies and Procedures have been modified for compliance:

Adverse Reimbursement Change – Effective 1/1/10
In accordance with Public Health Law 4406-c, Atlantis Health Plan providers will receive written notice from Atlantis at least 90 days prior to an adverse reimbursement change. Within 30 days of the date of the notice, the provider may terminate the contract, effective upon the date of 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. The following are statutory exceptions to this notice requirement:

1. The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and
2. The change is provided for in the contract between Atlantis and the provider or the IPA and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

Coordination of Benefits – Effective 1/1/10
In accordance with Insurance Law 3224-c, Atlantis cannot deny a claims, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless Atlantis has reasonable basis to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if Atlantis requests information from the member regarding other coverage, and does not receive the information within 45 days; Atlantis must adjudicate the claim. However, the claim cannot be denied on the basis of non-receipt of information about other coverage.

Timeframe for Claims Submissions – Effective for Dates of Service on or after 4/1/10
Insurance Law 3224-a was amended; providers must initially submit claims within 120 days after the date of service.

Reconsideration for Untimely Claims – Effective for Dates of Service on or after 4/1/10
Claims must be submitted by par providers within 120 days of the date of service. Atlantis will reconsider the denial of claim for untimely filing when the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions. Atlantis may reduce the reimbursement of a claim by up to 25% of the amount that would have been paid had the claim been submitted in a timely manner. This right to reconsideration does not apply to a claim submitted 365 days after the service and in such cases, Atlantis may deny the claim in full.

Overpayment Recovery – Effective 1/1/10
Other than recovery for duplicate payments, Atlantis shall provide 30 days written notice to health care providers before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims. Such notice shall state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

Atlantis shall provide a provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and will provide the provider the written policies and procedures for to challenge an overpayment recovery. Such challenge shall set forth the specific grounds on which the provider is challenging the overpayment recovery.

Atlantis shall not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members.

Claims from a Participating Health Care Provider Associated with a Non-participating Hospital Claim – Effective 1/1/10
Atlantis is prohibited from treating a claim from a network provider as out-of-network solely because the hospital is non-participating. Please note referrals by participating providers to non-participating providers must be approved by Atlantis Health Plan.

Credentialing – Effective 10/1/09
Atlantis shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the plan. The

plan shall consult with appropriately qualified health care professionals in developing its qualification requirements. Atlantis shall complete review of the health care professional's application to participate in the in-network portion of the plan's network and shall, within 90 days of receiving a health care professional's completed application to participate in the plan's network, notify the health care professional as to: (i) whether he or she is credentialed; or (ii) whether additional time is necessary to make a determination in spite of the plan's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible.

If the completed application of a newly-licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this state, who joins a group practice of health care professionals each of whom participates in the in-network portion of a plan's network, is neither approved nor declined within ninety days pursuant to paragraph (a) of this subdivision, the health care professional shall be deemed “provisionally credentialed" and may participate in the in-network portion of the plan's network; provided, however, that a provisionally credentialed physician may not be designated as an enrollee's primary care physician until such time as the physician has been fully credentialed.

The network participation for a provisionally credentialed health care professional shall begin on the day following the ninetieth day of receipt of the completed application and shall last until the final credentialing determination is made by the plan. A health care professional shall only be eligible for provisional credentialing if the group practice of health care professionals notifies the plan in writing that, should the application ultimately be denied, the health care professional or the group practice: (i) shall refund any payments made by the plan for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the enrollee's contract with Atlantis; and (ii) shall not pursue reimbursement from the enrollee, except to collect the copayment that otherwise would have been payable had the enrollee received services from a health care professional participating in the in-network portion of a plan's network. Interest and penalties pursuant to section three thousand two hundred twenty-four-a of the insurance law shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent Atlantis plan from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim. Atlantis shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

Rare Disease Treatment – Effective 1/1/10
Public Health Law Article 49 was amended to include external appeal rights for rare disease treatment.

Provider External Appeals and Member Hold Harmless – Effective 1/1/10
If a member’s health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the plan's determination in whole, payment for the external appeal shall be made by the health care provider.

If a member’s health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the plan's determination in part, payment for the external appeal shall be evenly divided between the plan and the member's health care provider who requested the external appeal and shall be made by the plan and the member's health care provider; provided, however, that the superintendent may, upon a determination that plans or health care providers are experiencing a substantial hardship as a result of payment for the external appeal when the external appeal agent upholds the plan's determination in part, in consultation with the commissioner of health, promulgate regulations to limit such hardship.

If a member’s health care provider was acting as the member's designee, payment for the external appeal shall be made by the plan. The external appeal and any designation shall be submitted on a standard form developed by the superintendent in consultation with the commissioner of health. The superintendent shall have the authority upon receipt of an external appeal to confirm the designation or request other information as necessary, in which case the superintendent shall make at least two written requests to the member to confirm the designation. The member shall have two weeks to respond to each such request. If the member fails to respond to the superintendent within the specified timeframe, the superintendent shall make two written requests to the health care provider to file an external appeal on his or her own behalf. The health care provider shall have two weeks to respond to each such request. If the health care provider does not respond to the superintendent's requests within the specified timeframe, the superintendent shall reject the appeal. If the health care provider responds to the superintendent's requests, payment for the external appeal shall be made in accordance with Public Health Law.

Hold harmless:
A health care provider requesting an external appeal of a concurrent adverse determination, including when the health care provider requests an external appeal as the member’s designee, shall not pursue reimbursement from the member for services determined not medically necessary by the external appeal agent, except to collect a copayment, coinsurance or deductible.