



**STATE OF NEW YORK
INSURANCE DEPARTMENT**

AGENCY BUILDING ONE
EMPIRE STATE PLAZA
ALBANY, NY 12257

**Circular Letter No. 1 (2002)
January 18, 2002**

**TO: ALL INSURERS LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE IN NEW YORK STATE,
INCLUDING ARTICLE 43 CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS**

RE: CLARIFICATION OF EMERGENCY CARE COVERAGE

**STATUTORY REFERENCES: Insurance Law Sections 3216, 3221, 4303 and Article 49; Public Health Law
Article 49**

Insurance Law Sections 3216(i)(9), 3221(k)(4) and 4303(a)(2) mandate coverage of services to treat an emergency condition in hospital facilities and define an "emergency condition" as follows:

"Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

Issues have recently arisen concerning claims adjudication using the prudent person standard, appeal rights and improper conditions placed on coverage. The purpose of this Circular Letter is to set forth the Department's position with regard to the administration of this mandated benefit for emergency services.

CLAIMS ADJUDICATION

It has come to our attention that insurers, Article 43 corporations and HMOs may be denying coverage for emergency services based upon the final diagnosis code, such as ICD 9 or CPT 4 codes, assigned to the emergency room visits. Although the diagnosis code may be used to approve coverage of emergency services, its use as the basis for denial of coverage is improper. The standard by which to evaluate whether a denial of coverage is supportable is the "prudent layperson" standard required by the Insurance Law. Whenever a claim is denied, the determination of whether the prudent layperson standard has been met (1) must be based on all pertinent documentation, (2) must be focused on the presenting symptoms and not on the final diagnosis and (3) must take into account that the decision to seek emergency services was made by a prudent layperson rather than a medical professional.

APPEAL RIGHTS

Article 49 of the Insurance Law, in Sections 4900(c), 4901(a)(5), 4902(a)(8) and 4905(m), recognizes that determination of coverage of emergency services is a function of the utilization review process. Section 4901(a)(5) requires that the utilization review report filed with the Department contain a description of the emergency care policy. Section 4902(a)(8) requires that a utilization review agent adhere to program standards that include a requirement that emergency services rendered to an insured shall not be subject to prior authorization. That Section further requires that reimbursement for such services not be denied on retrospective review; provided however, that such services are medically necessary to stabilize or treat an emergency condition. Finally, Section 4905 prohibits a prior notice requirement on receipt of emergency care. Identical provisions in the Public Health Law make these requirements applicable to HMOs.

Because the statutory benefit for emergency services employs the prudent layperson standard discussed above, any assessment of medical necessity for emergency services pursuant to Article 49 must take this standard into account. Emergency services rendered by hospital facilities would be medically necessary if they were provided in treatment of an emergency condition. When, pursuant to Section 4902(a)(8), retrospective review results in a finding that emergency services were not medically necessary, it must be because under a prudent layperson standard the services were not rendered to treat an emergency condition.

In the event of a denial, the insured, his or her designee and the provider shall be afforded appeal rights consistent with Article 49. However, at each level of appeal, the prudent layperson standard must be applied in assessing whether the emergency services were medically necessary.

NOTIFICATION REQUIREMENTS

Many insurance policies and subscriber contracts contain provisions that would require the insured or someone on the insured's behalf to notify the insurer within a contractually established timeframe that emergency services were received. These post-emergency notification procedures do not appear in statute and were permitted by the Department administratively based on arguments by health plans that notice was necessary so that the health plans could coordinate follow-up care and assure access to quality and appropriate services. Since the sweeping changes made to the law since 1997 to address how managed care plans provide health care services, we have had reason to reassess allowing post-emergency notification requirements.

In some cases, health plans use the notice requirements to deny or reduce benefits of an otherwise appropriate access of emergency care. Since the Insurance Law mandates coverage of emergency services received in hospital facilities and it does not condition such coverage on the insured giving notice to the health plan of the receipt of such care (apart from submitting a claim for services), the failure by the insured to give notice should not be considered in making a decision to cover the services in question. To deny or reduce benefits on this basis would be inconsistent with the Insurance Law.

We appreciate, however, the importance of a health plan's ability to manage and coordinate care under a managed care plan. We are willing to continue to approve provisions that discuss notification by the insured so long as such notification is suggested rather than required and no reduction or denial of benefits for receipt of otherwise covered emergency services results from a failure to notify. Health plans are directed to review both their contract provisions and their policy and procedures for processing claims for emergency care and make required changes consistent with this Circular Letter.

Any questions on this Circular Letter may be directed to:

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