

Assessment of Public Comments for new Part 400 to 23 NYCRR.

The Department of Financial Services (“Department”) received comments from ten interested persons in response to its proposed new Part 400 to 23 NYCRR, some of which were incorporated into the emergency and revised rulemaking, discussed below.

Comments:

Commenters requested that 23 NYCRR Section 400.1 apply to coverage in the New York State of Health (NYSOH) and to certain out-of-state services, and questioned whether the regulation applies to dental coverage.

Response:

The independent dispute resolution (IDR) process applies to NYSOH coverage. The IDR process is not applicable to stand-alone dental coverage. Dental services do not meet the definition of “surprise bill” because a participating physician would not be providing the referral or services and dental coverage would not typically cover emergency services as defined in Financial Services Law Section 603.

A service associated with a surprise bill need not be provided in its entirety in New York to be subject to the IDR process. E.g., an insured is covered under an HMO or insurance policy or contract that is issued for delivery in New York and has blood drawn in New York by a participating physician. The participating physician sends the sample to an out-of-state laboratory that regularly conducts business with the New York provider. In such cases, the laboratory may be providing services in New York and subject to the IDR process. The intent of the legislation is to protect patients from surprise bills when they receive services from their participating physicians in New York.

Comments:

Commenters requested revision of the 23 NYCRR Section 400.2 definitions of “reviewer” to remove the requirement for experience with usual and customary costs, “reviewing physician” to add conflict of interest standards, and “usual and customary cost”.

Response:

The definition of “reviewer” was not revised because Financial Services Law Section 604 requires the IDRE to consider the usual and customary cost. The definition of “reviewing physician” was not revised because conflict of interest prohibitions are in 23 NYCRR Section 400.4(d). The definition of “usual and customary cost” was revised to mirror the definition in Financial Services Law Section 603(i). The database referenced in the definition of “usual and customary cost” is not expected to include all charges for each health care service. It is understood that some charges may not be reported to the database.

Comments:

Commenters requested revisions to 23 NYCRR Sections 400.3 and 400.4 to (1) prohibit IDREs from reviewing disputes when they acquire or become controlled by an advocacy group or association of providers or health plans; (2) include officers, directors, or managers of a physician’s medical group, independent practice association, or health care facility when determining conflicts of interests for IDREs; (3) prohibit a reviewer or physician from reviewing a dispute when they have a conflict with an affiliate of the health plan involved in the dispute when all IDREs have disqualifying conflicts of interest; (4) prohibit the reviewing physician from contracting to participate with the health plan that is a party to the dispute; (5) require the reviewing physician to be retired or prohibited from providing out-of-network services; and (6) remove the control test for determining IDRE conflicts of interest.

Response:

The regulation incorporates the changes requested in (1) – (3).

The regulation does not incorporate the changes requested in (4) – (6). Financial Services Law Section 601 requires IDREs to use licensed physicians in active practice in the same or similar specialty as the physician providing the service and, to the extent practicable, the physicians must be licensed in New York. Including retired physicians in the IDRE panel is not permitted. Prohibiting reviewing physicians from providing out-of-network services would limit the IDRE’s ability to attract physicians to its panel. The reviewing physician may not review disputes involving a health plan when the reviewing physician has a material familial, financial or professional affiliation with the health plan. The control test is necessary to identify what constitutes a conflict of interest.

Comments:

Commenters requested revisions to 23 NYCRR Section 400.5 to (1) only require the health plan to provide the insured with IDRE information when it pays less than the provider’s charge; (2) remove the reference to a substantially similar assignment of benefits form; (3) set a timeframe for payment to the physician or provider when the IDRE finds in their favor; (4) remove the requirement for health plans to provide notice describing how to initiate the IDR process when the non-participating physician submits the claim; (5) remove the requirement for health plans to provide notice to insureds when health plans determine a bill is a surprise bill before receipt of the assignment of benefits form; (6) limit the health plan’s obligation to notify the insured that the claim could be a surprise bill to claims from providers likely to have surprise bills; and (7) reiterate that the IDR process is not applicable to certain emergency services specifically exempted by law. Commenters also questioned the applicability of the hold harmless protection to surprise bills, and the effective dates for the hold harmless protections for emergency services.

Response:

The regulation incorporates the changes requested in (1) – (2), and also requires the health plan to pay additional amounts to the provider within 30 days of the IDRE’s determination.

The requirement to send the non-participating physician notice was not changed, as it is important that physicians be informed of the IDR process during the claim adjudication process.

The provision requiring notice when a health plan otherwise determines that a bill is a surprise bill was not removed. Some health plans are able to identify surprise bills upon claim submission and the regulation does not impose an obligation on health plans that are unable to identify a surprise bill without an assignment of benefits form. The requested change to limit notice only when the claim involves a provider likely to have surprise bills was not made. Consumers must be informed of their protections, and the notification requirements are not burdensome.

23 NYCRR Section 400.1 states that the regulation does not apply to emergency services subject to Financial Services Law Section 602(b).

The requested change regarding the hold harmless protection for surprise bills was not made. The intent of the legislation was to remove insureds from payment disputes between health plans and providers. The legislation requires health plans to provide coverage for surprise bills and specifically provides that the insured cannot be subject to any greater out-of-pocket costs than the insured would have incurred with a participating physician or provider.

The regulation was revised to address the varying effective dates for the hold harmless provisions for emergency services.

Comments:

Commenters requested changes to 23 NYCRR Section 400.6 to (1) remove the requirement that non-participating referred health care providers include a claim form and an assignment of benefits form when they bill patients; (2) permit a non-participating physician to have “at least” seven business days to respond to a health plan’s offer, except when the seven business days would cause the health plan to violate Insurance Law

Section 3224-a; and (3) prohibit physicians from seeking payment for emergency services beyond the health plan's payment once a claim has been submitted to the IDRE.

Response:

The regulation incorporates the change requested in (1). The regulation was also revised to allow the non-participating physician or provider "at least" seven business days to respond to a health plan's offer. This provision is intended to allow the provider time to respond but was never intended to permit the health plan to delay payment.

Once an IDRE renders a determination, the parties are bound by the determination and insureds are only responsible for their in-network cost-sharing.

Comments:

Commenters requested changes to 23 NYCRR Section 400.7 to (1) require the fees submitted by the health plan to represent the final payment to the physician; (2) extend the period of time for fee information to 24 months; (3) permit multiple CPT codes to be submitted if more than one is applicable to a patient; (4) delete the references to "if applicable" and "if available" after "usual and customary cost"; (5) prohibit health plans from submitting Medicaid, Medicare, or other network fee data to the IDRE; (6) remove the usual and customary cost from the information that health plans and providers submit; (7) require health plans to provide the names and numbers for the physicians who received the listed payments; and (8) clarify the criteria used to determine a gross disparity when determining a reasonable fee.

Response:

The regulation was revised to (1) provide that the fee information must reflect the final payment; and (2) permit fee examples from the last 24 months, because physicians and health plans may not have three examples from the previous 12 months for services that are infrequently provided.

The IDR process will review the services provided to the patient, which may consist of one or many procedure codes.

The language “if applicable” was intended to address when the usual and customary cost does not exist. The Department added language that the usual and customary cost is to be provided when the benchmarking database contains the usual and customary cost for the service.

The intent of the term “if available” was to permit physicians to submit the usual and customary cost if they have access to the information, but not require them to submit it. The regulation was revised to remove the physician’s and provider’s obligation to submit the usual and customary cost.

The regulation requires health plans to provide the usual and customary cost since they likely have access to the information. If the IDRE gains access to the usual and customary cost data in a cost efficient manner, the Department will consider removing the requirement.

Financial Services Law Section 604 requires the IDRE to consider specifically enumerated factors, including the usual and customary cost but not including other rates. The law does not prohibit any other information from being submitted. However, the IDRE is not bound by additional information submitted.

With respect to the health plan providing the names and contact numbers for the physicians who received the payments, the regulation provides that the IDRE may request any information it needs from the parties to the IDR.

The IDRE must consider the criteria found in Financial Services Law Section 604 to determine a gross disparity.

Comments:

The Department received comments requesting revisions to 23 NYCRR Section 400.8 of the regulation to (1) state that the IDRE must choose either the health plan’s payment or the provider’s charge; (2) require the

IDRE to divulge the name of the reviewer and reviewing physician; and (3) permit an appeal of a dispute in cases of gross negligence or abuse of discretion by an IDRE.

Response:

The regulation was changed to reference requirements in Financial Services Law Sections 605 and 607 that the IDRE choose either the health plan's payment or the provider's charge.

Changes were not made to require the IDRE to divulge the reviewer or reviewing physician. Anonymity provides the reviewer and the reviewing physician the ability to independently determine the dispute without the concern that they could be contacted by the parties involved in the dispute. IDREs may have difficulty attracting reviewers and physicians to their panels if their identity is revealed. IDREs will provide biographies to show the reviewers meet the qualifications required to review disputes.

Finality of the IDR is important for the process to run effectively and the law states that the decision is binding but admissible in court proceedings.

Comment:

A commenter recommended revising 23 NYCRR Section 400.9(e) to require IDREs to comply with privacy and confidentiality requirements.

Response:

The Department added a requirement that the IDRE comply with Parts 420 and 421 of 11 NYCRR with respect to confidentiality of information.

Comments:

Commenters requested (1) dispute information be made available upon request to the Department; (2) the cost of the IDR process should be low; (3) the penalties for violating Insurance Law Section 2601(a)(7) be added; (4) the IDR process favor the physician's bill; and (5) the effective date be changed to April 1, 2015.

Response:

(1) Requests made to the Department for dispute information will be individually reviewed and determined in accordance with applicable law.

(2) The regulation does not address actual costs of the IDR process; only the party responsible to pay the costs.

(3) The regulation does not specify the penalties for violating Insurance Law Section 2601(a)(7) because they are specified in Insurance Law Section 109.

(4) The IDR process was intended to provide an independent, unbiased review for physician and health plan billing disputes.

(5) An effective date set by law cannot be changed by regulation.