NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
FIRST AMENDMENT TO 23 NYCRR 400

INDEPENDENT DISPUTE RESOLUTION FOR EMERGENCY SERVICES AND SURPRISE BILLS

I, Linda A. Lacewell, Superintendent of Financial Services, pursuant to the authority granted by Sections 202, 301, 302, and Article 6 of the Financial Services Law, and Section 301 of the Insurance Law, do hereby promulgate the following First Amendment to Part 400 of Title 23 of the Official Compilation of Codes, Rules and Regulations of the State of New York to take effect 30 days after publication of the Notice of Adoption in the State Register, to read as follows:

(NEW MATTER UNDERSCORED; DELETED MATTER IN BRACKETS)

Section 400.0 is amended to read as follows:

Part H of Chapter 60 of the Laws of 2014 provided new rights and obligations, effective March 31, 2015, concerning disputes involving bills by health care providers. Health care plans, physicians, and when applicable, other health care providers and patients, have the right to request a review by an IDRE to resolve a payment dispute regarding a bill for certain emergency services or surprise bills. Chapters 375 and 377 of the Laws of 2019, effective January 1, 2020, provided additional rights and obligations for disputes involving hospital bills for emergency services and inpatient services that follow an emergency room visit. Part YY of Chapter 56 of the Laws of 2020, effective April 3, 2020, provided new hold harmless requirements and assignment of benefits rights and obligations for emergency services, including inpatient services, that follow an emergency room visit. This Part implements the requirements of Financial Services Law Article 6 by establishing a dispute resolution process and establishing the standards for such process, including criteria and the process for certifying and selecting an IDRE.

Subdivision 400.1(a) is amended and a new subdivision (c) is added to read as follows:

(a) This Part shall apply to health care services provided in this State on and after March 31, 2015. This Part also shall apply to emergency services provided by non-participating hospitals and inpatient services that follow an emergency room visit provided in this State on and after January 1, 2020. The requirements relating to assignment of benefits and provider hold harmless for emergency services in subdivisions (a)(2) and (b)(2) of section 400.6 of this Part shall apply to emergency services provided in this State on and after April 3, 2020.

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(c) The requirements of this Part for emergency services provided by non-participating hospitals, including inpatient services that follow an emergency admission, shall not apply to hospitals that had at least 60 percent of inpatient discharges annually that consisted of Medicaid, uninsured, and dual eligible individuals as determined by the department of health in its determination of safety net hospitals.

Subdivision 400.2(d) is amended as follows:

(d) *Dispute resolution process* means a process to resolve a dispute for a fee for emergency services, including inpatient services that follow an emergency room visit, or a surprise bill.

Subdivisions 400.2(i) to (v) are re-lettered as subdivisions (j) to (w), and a new subdivision (i) is added as follows:

(i) *Hospital* means a general hospital operating pursuant to Public Health Law Article 28.

Subdivision 400.3(a) is amended to read as follows:

(a) An entity applying to be an IDRE certified to perform reviews regarding bills for emergency services, including inpatient services that follow an emergency room visit, and surprise bills pursuant to Financial Services Law Article 6 shall submit to the superintendent:

(1) a description of the proposed IDRE's organizational structure and capability to operate a statewide IDRE, including:

(i) a certificate of incorporation, articles of organization and bylaws or operating agreement of the proposed IDRE and, as applicable, those of the proposed IDRE's holding company or parent company;

(ii) the proposed IDRE's organizational chart;

(iii) identification of management staff and a description of such management staff's responsibilities;

(iv) the name and credentials of a medical director appointed by the proposed IDRE, who is a physician in possession of a current and valid non-restricted license to practice medicine in New York;

(v) the names and biographies of all controlling employees, officers, and executives of the proposed IDRE; and information concerning the governing board of the proposed IDRE, including roles and responsibilities, identification of the board members and a description of their qualifications;

(2) a sworn statement, as described in section 400.4(b) of this Part, signed by the chief executive officer of the proposed IDRE regarding conflicts of interest;

(3) the names of all corporations and organizations that control, are controlled by, or under common control with the proposed IDRE, and the nature and extent of any such control;

(4) the proposed IDRE's policies and procedures governing all aspects of the dispute resolution process, including at a minimum:

(i) a description and a chart or diagram of the sequence of steps through which a dispute will move from receipt through notification to the health care plan, physician, superintendent, and provider, insured, or patient, if applicable, regarding the dispute determination;

(ii) procedures for ensuring that no prohibited material familial, financial or professional affiliation exists with respect to the reviewer and reviewing physician assigned to the dispute. The procedures shall include, for each reviewer and reviewing physician assigned to review a dispute, a requirement for a signed attestation affirming, under penalty of perjury, that no prohibited material familial, financial or professional affiliation exists with respect to the reviewer's or reviewing physician's participation in the review of the dispute;

(iii) procedures to ensure that the dispute is reviewed by a neutral and impartial reviewer with training and experience in healthcare billing, reimbursement, and usual and customary charges and determinations are made in consultation with a neutral and impartial licensed reviewing physician in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute, who is also, to the extent practicable, licensed in New York;

(iv) procedures for the reporting and review of reviewer's and reviewing physician's conflicts of interest and for assigning or reassigning a dispute resolution where a conflict or potential conflict is identified;

(v) procedures to ensure that reviews are conducted within the time frames specified in section 400.8 of this Part and any required notices are provided in a timely manner;

(vi) procedures to ensure the confidentiality of medical and treatment records and review materials; and

(vii) procedures to ensure adherence to the requirements of this Part by any contractor, subcontractor, agent or employee affiliated by contract or otherwise with the proposed IDRE;

(5) a description of the reviewer and reviewing physician network, including:

(i) an assessment of the proposed IDRE's ability to provide review services statewide;

(ii) a description of the qualifications of the reviewers and reviewing physicians retained to review payment disputes, including current and past employment history and practice affiliations, as applicable;

(iii) a description of the procedures employed to ensure that reviewers and reviewing physicians reviewing payment disputes are:

(a) appropriately licensed, registered or certified, if applicable;

(b) trained in the principles, procedures and standards of the proposed IDRE;

(c) knowledgeable about the health care service which is the subject of the payment dispute under review; and

(d) with respect to reviewers, trained and experienced in health care billing, reimbursement and usual and customary charges;

(iv) a description of the methods of recruiting and selecting neutral and impartial reviewers and reviewing physicians and matching such reviewers and reviewing physicians to specific cases;

(v) the number of reviewers and reviewing physicians retained by the proposed IDRE, and a description of the areas of expertise available from reviewing physicians and the types of cases reviewing physicians are qualified to review;

(vi) the proposed IDRE's quality assurance program, which shall include written descriptions, to be provided to all individuals involved in such program; the organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in payment dispute reviews performed by the reviewer and reviewing physician; and the maintenance of program standards pursuant to this subdivision; and

(vii) written procedures documenting that:

(a) appropriate personnel are reasonably accessible not less than 40 hours per week during normal business hours to discuss the dispute resolution process and to allow response to telephone requests;

(b) a response to an accepted or recorded message shall be made not less than one business day after the date on which the call was received; and

(viii) documentation of accreditation by a nationally recognized private accrediting organization, if accreditation is available;

(6) a list of its fees, which shall reflect the total amount that will be charged by the proposed IDRE for reviews, inclusive of indirect costs, administrative fees and incidental expenses, and a description of the methodology used to calculate the fees. The description shall include the pro-rated fee that will be charged when a good faith negotiation directed by the proposed IDRE results in a settlement between the health care plan and the non-participating physician, non-participating hospital, or non-participating referred health care provider. The description also shall [also] include an application processing fee when the dispute is determined by the proposed IDRE to be ineligible for review. The description shall provide a waiver of the fee for disputes submitted by patients when the fee would pose a financial hardship to the patient;

(7) a description of the proposed IDRE's ability to accept requests for reviews, provide requisite notifications, screen for material affiliations, respond to calls from the State and meet other requirements during normal business hours; and

(8) such other information as the superintendent may require.

Subdivision 400.5(a) is amended to read as follows:

(a) Upon receipt of a claim for emergency services, including inpatient services that follow an emergency room visit, rendered by a non-participating physician or a non-participating hospital, a health care plan shall:

(1)(i) pay the claim, within the timeframes established in Insurance Law section 3224-a, in an amount that it deems reasonable for the [emergency] services rendered by the non-participating physician or non-participating hospital that had not previously entered into a participating provider agreement with the health care plan, except for the insured's co-payment, coinsurance or deductible, if any[.]; or

(ii) in disputes involving a non-participating hospital that had previously entered into a participating provider agreement with the health care plan, pay the claim, within the timeframes established in Insurance Law section 3224-a, in an initial amount that is at least 25 percent greater than the amount the health care plan would have paid for the claim had the hospital been in-network, based on the most recent participating provider agreement between the health care plan and the non-participating hospital, except for the insured's co-payment, coinsurance or deductible, if any. In the event the prior participating provider agreement between the health care plan and the non-participating hospital expired more than 12 months prior to the payment of the disputed claim, the payment amount shall be adjusted based upon the annual medical consumer price index, compounded for each year subsequent to the year the contract terminated up until the year the claim is paid. If a health care plan believes that this initial payment amount to a non-participating hospital with which it had previously entered into a participating provider agreement is not reasonable, it may submit a dispute to the superintendent for review by an IDRE, as provided in section 400.7 of this Part, and propose an amount it deems reasonable, provided that the health care plan:

(*a*) notifies the non-participating hospital of its intent to submit the dispute to the superintendent, together with the health care plan's best and final offer and an explanation of the calculation, including the aggregation or any other methodology used by the health care plan to develop its best and final offer;

(*b*) provides the non-participating hospital with 15 business days to respond to the health care plan with the non-participating hospital's best and final offer before submitting the dispute to the superintendent;

(*c*) includes its best and final offer and the non-participating hospital's best and final offer, if any, in its submission of the dispute to the superintendent; and

(*d*) notifies the non-participating hospital of the dispute at the time of the submission to the superintendent; and

(iii) [Nothing shall preclude the health care plan] not be precluded from attempting to negotiate the reimbursement amount with the non-participating physician or non-participating hospital within the timeframes established in Insurance Law section 3224-a;

(2) if the claim is submitted by the non-participating physician or non-participating hospital, or if payment is made to the non-participating physician or non-participating hospital, provide notice to the non-participating physician or non-participating hospital describing how to initiate the independent dispute resolution process; [and]

(3) if the health care plan pays an amount less than the non-participating physician's or non-participating hospital's charge, provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall:

(i) explain that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or participating hospital;

(ii) explain that the insured's cost-sharing may increase in the event the IDRE determines that the health care plan must pay additional amounts for the services of the non-participating physician or non-participating hospital; and

(iii) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating hospital bills the insured for the out-of-network service other than the insured's in-network copayment, coinsurance, or deductible; and

(4) pay the amount set forth in subparagraph (i) or (ii) of paragraph (1) of this subdivision directly to the non-participating physician or non-participating hospital if an insured assigns benefits to the non-participating physician or non-participating hospital.

Subparagraph (iii) of paragraph (3) of subdivision 400.5(b) is amended to read as follows:

(iii) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating referred health care provider bills the insured for the out-of-network service other than the insured's in-network copayment, coinsurance, or deductible.

Subdivisions 400.5(c) and (d) are amended to read as follows:

(c) Upon receipt of a claim for the services of a non-participating physician or a non-participating referred health care provider that could be a surprise bill and that is not submitted with an assignment of benefits form, the health care plan shall provide the insured with notice, included on or in conjunction with, an explanation of benefits, which shall:

(1) advise the insured that the claim could be a surprise bill [and that];

(2) explain that if the claim is a surprise bill and the insured submits an assignment of benefits form, the insured will incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or health care provider; and

(3) direct the insured [should] to contact the health care plan or visit the health care plan's website for additional information regarding surprise bills and to obtain an assignment of benefits form for surprise bills.

(d) If the health care plan receives a claim for services of a non-participating health care provider that could be a surprise bill that is not submitted with an assignment of benefits form and the health care plan denies the claim because the health care provider is a non-participating provider, the health care plan shall, upon receipt of the assignment of benefits form, comply with the requirements of subdivision (b) of this section.

Subparagraph (iv) of paragraph (2) of subdivision 400.5(e) is amended to read as follows:

(iv) direct the insured to contact the health care plan in the event that the non-participating physician or non-participating referred health care provider bills the insured for the out-of-network service other than the insured's in-network copayment, coinsurance, or deductible; and

Subdivisions 400.5(f), (g), (h), (i), and (j) are amended and a new subdivision (l) is added to read as follows:

(f) A health care plan shall prominently post on its website the information in paragraphs (1) – (5) of this subdivision and include in disclosure materials provided to insureds pursuant to Insurance Law sections 3217-

a(a), 4324(a) and Public Health Law section 4408(1) the information in paragraphs (1) – (4) of this subdivision, as follows:

(1) a description of what constitutes a surprise bill;

(2) a description of the independent dispute resolution process;

(3) an assignment of benefits form for surprise bills;

(4) the health care plan's designated electronic and mailing address where the assignment of benefits form can be submitted; and

(5) information on how an insured, non-participating physician, non-participating hospital, or, as applicable, a non-participating referred health care provider, may submit a dispute to an IDRE.

(g) An assignment of benefits form for surprise bills shall be in a form prescribed by the superintendent.

(h) A health care plan shall ensure that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician, participating hospital, or participating health care provider:

(1) for emergency services, [subject to Insurance Law section 3241(c) upon policy or contract issuance or renewal on and after March 31, 2015 and for emergency services listed in Financial Services Law section 602(b) on March 31, 2015 regardless of policy or contract issuance or renewal] including inpatient services that follow an emergency room visit; and

(2) for a dispute involving a surprise bill when the insured has assigned benefits to a non-participating physician or a non-participating referred health care provider.

(i) If the IDRE directs the health care plan to engage in negotiations with the non-participating physician, non-participating hospital, or non-participating referred health care provider the health care plan shall do so in good faith. If a settlement is reached, the health care plan shall notify the IDRE within two business days of the settlement and shall make any additional payment to the non-participating physician, non-participating hospital, or non-participating referred health care provider within the timeframes prescribed in Insurance Law section 3224-a. If a settlement is not reached or the parties agree that a settlement is not attainable, the health care plan shall promptly notify the IDRE no later than the end of the time period granted by the IDRE for negotiation.

(j) If the IDRE issues a determination in favor of the non-participating physician, non-participating hospital, or non-participating referred health care provider, the health care plan shall pay the non-participating physician, non-participating hospital, or, as applicable, the non-participating referred health care provider, any additional amount owed within 30 days from the date of the determination.

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(l)(1) If a health care plan receives an assignment of benefits form for a surprise bill and determines that the bill is not a surprise bill, the health care plan shall provide written notice of such determination. The notice

shall include the procedures for filing a grievance under Insurance Law section 4802 or Public Health Law section 4408-a and information on how to file a complaint with the superintendent.

(2) If a health care plan makes a determination on a grievance disputing that a bill is a surprise bill, the health care plan shall comply with the Insurance Law section 4802 or Public Health Law section 4408-a grievance requirements.

Section 400.6 is amended to read as follows:

Section 400.6 Responsibilities of physicians, hospitals, and non-participating referred health care providers for disputes regarding emergency services and surprise bills.

(a)(1) If a non-participating physician or non-participating referred health care provider bills a patient for a surprise bill, the non-participating physician or non-participating referred health care provider shall provide a claim form to the patient and an assignment of benefits form in a form prescribed by the superintendent.

(2) If a non-participating physician or a non-participating hospital bills a patient for emergency services, including inpatient services that follow an emergency room visit, the non-participating physician or non-participating hospital shall provide a claim form and an assignment of benefits form to the patient.

(b)(1) If an insured assigns benefits for a surprise bill in writing to a non-participating physician or nonparticipating referred health care provider that knows the insured is insured under a health care plan, the nonparticipating physician or non-participating referred health care provider shall not bill or seek payment from the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

(2) If an insured assigns benefits for emergency services, including inpatient services that follow an emergency room visit, to a non-participating physician or non-participating hospital that knows the insured is insured under a health care plan, the non-participating physician or non-participating hospital shall not bill or seek payment from the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician or hospital.

(c) If a health care plan attempts to negotiate reimbursement with a non-participating physician, non-participating hospital that had not previously entered into a participating provider agreement with the health care plan, or non-participating referred health care provider, the non-participating physician, non-participating hospital, or non-participating referred health care provider shall have at least seven business days to respond to the health care plan's offer, except when the seven business days would exceed the timeframes established in Insurance Law section 3224-a for a health care plan to pay a claim.

(d) In disputes involving emergency services, including inpatient services that follow an emergency room visit, rendered by a non-participating hospital that had previously entered into a participating provider agreement with a health care plan, if the non-participating hospital believes that the initial payment amount paid pursuant to subparagraph (ii) of paragraph (1) of subdivision (a) of section 400.5 of this Part by the health care plan is not reasonable, the non-participating hospital may submit a dispute to the superintendent for review by an IDRE, as provided in section 400.7 of this Part, and propose an amount it deems reasonable, provided that the non-participating hospital:

(1) notifies the health care plan of its intent to submit the dispute to the superintendent, together with the non-participating hospital's best and final offer and an explanation of the calculation, including the aggregation or any other methodology used by the non-participating hospital to develop its best and final offer;

(2) provides the health care plan with 15 business days to respond to the non-participating hospital with the health care plan's best and final offer before submitting the dispute to the superintendent;

(3) includes its best and final offer and the health care plan's best and final offer, if any, in its submission of the dispute to the superintendent; and

(4) notifies the health care plan of the dispute at the time of the submission to the superintendent.

(e) If the IDRE directs the non-participating physician, non-participating hospital, or non-participating referred health care provider to engage in negotiations with the health care plan, the non-participating physician, non-participating hospital, or non-participating referred health care provider shall do so in good faith. If a settlement is reached, the non-participating physician, non-participating hospital, or nonparticipating referred health care provider shall notify the IDRE within two business days of the settlement. If a settlement is not reached or the parties agree that a settlement is not attainable, the non-participating physician, non-participating hospital, or non-participating referred health care provider shall promptly notify the IDRE no later than the end of the time period granted by the IDRE for negotiation.

[(e)] (f) A non-participating physician, non-participating hospital, or non-participating referred health care provider shall respond to all inquiries from the superintendent relating to the dispute resolution process within three business days.

(g) If the IDRE issues a determination in favor of the health care plan in a dispute involving emergency services provided by a non-participating hospital that had previously entered into a participating provider agreement with the health care plan, including inpatient services that follow an emergency room visit, the non-participating hospital shall pay any amount owed to the health care plan within 30 days from the date of the determination.

Subdivisions 400.7(a), (c), (d), (e), (f), and (g) are amended to read as follows:

(a)(1) Emergency services. A health care plan, a non-participating physician, a non-participating hospital, or a patient who is not an insured may submit a dispute regarding emergency services, [rendered by a physician] including inpatient services that follow an emergency room visit, to the superintendent for review by an IDRE.

(2) Surprise bills. A health care plan, a non-participating physician, a non-participating referred health care provider, an insured who does not assign benefits, or a patient who is not an insured may submit a dispute regarding a surprise bill to the superintendent for review by an IDRE.

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(c) A health care plan shall provide the following information:

(1) the name and contact information of the health care plan;

(2) the name and contact information of the non-participating physician, non-participating hospital, or non-participating referred health care provider;

(3) the fee charged by the non-participating physician, non-participating hospital, or non-participating referred health care provider for the service that is the subject of the dispute, and provide a copy of the bill;

(4) the fee paid to the non-participating physician, non-participating hospital, or non-participating referred health care provider for the service that is the subject of the dispute;

(5) at least three fees paid in the last 24 months by the health care plan to reimburse similarly qualified non-participating physicians, non-participating hospitals, or [, if the dispute involves a health care provider, a] non-participating referred health care [provider] providers for the same services in the same region that reflect the final and full payment to the non-participating physician, non-participating hospital, or the non-participating referred health care provider, if available;

(6) an explanation of the circumstances and complexity of the particular case, including time and place of the service, if available;

(7) individual patient characteristics, if available;

(8) for a dispute involving a non-participating physician, the usual and customary cost for the service, when the benchmarking database contains the usual and customary cost for the service subject to the dispute;

(9) for a dispute involving a non-participating hospital that had previously entered into a participating provider agreement with the health care plan, for emergency services, including inpatient services that follow an emergency room visit, the health care plan's best and final offer, if different from the payment made pursuant to subparagraph (ii) of paragraph (1) of subdivision (a) of section 400.5 of this Part, and the non-participating hospital's best and final offer, if any;

(10) any other information the health care plan deems relevant;

(11) the patient's coverage type;

[(10)] (12) an attestation affirming that the information provided by the health care plan is true and accurate; and

[(11)] (13) any information requested by the IDRE.

(d) A non-participating physician, non-participating hospital, or non-participating referred health care provider shall provide the following information:

(1) the name and contact information of the physician, hospital, or non-participating referred health care provider;

(2) the name and contact information of the health care plan;

(3) the fee charged by the physician, hospital, or non-participating referred health care provider for the service that is the subject of the dispute and a copy of the bill;

(4) the fee paid to the physician, hospital, or non-participating referred health care provider for the service that is the subject of the dispute;

(5) at least three fees paid to the physician, hospital, or ~~[, if the dispute involves a health care provider to the~~] nonparticipating referred health care provider, in the last 24 months for the same services rendered by the physician, hospital, or non-participating referred health care provider to other patients in health care plans in which the physician, hospital, or non-participating referred health care provider is not participating that reflect the final and full payment to the non-participating physician, non-participating hospital, or the non-participating health care provider, if available;

(6) the physician's, hospital's, or non-participating referred health care provider's usual charge for comparable services rendered to other patients in health care plans in which the physician, hospital, or non-participating referred health care provider is not participating;

(7) the physician's or non-participating referred health care provider's level of training, education and experience;

(8) for a dispute involving a non-participating hospital, the non-participating hospital's teaching status, scope of services, and case mix;

(9) an explanation of the circumstances and complexity of the particular case, including time and place of the service;

[(9)] (10) individual patient characteristics;

[(10)] (11) any other information the physician, hospital, or non-participating referred health care provider deems relevant;

[(11)] (12) an attestation affirming that the information provided by the physician, hospital, or non-participating referred health care provider is true and accurate; and

[(12)] (13) any information requested by the IDRE.

(e) Patients submitting the dispute shall provide the following information:

(1) the name and contact information of the patient;

(2) the name and contact information of the physician, hospital, or non-participating referred health care provider;

(3) the name and contact information of the health care plan, if the patient is an insured;

(4) the fee charged by the physician, hospital, or non-participating referred health care provider for the service that is the subject of the dispute and a copy of the bill;

(5) an explanation of the circumstances and complexity of the particular case, including time and place of the service;

(6) individual patient characteristics, if available;

(7) any other information the patient deems relevant;

(8) a consent to the release of medical information;

(9) with respect to a patient who is not an insured and who requests a waiver of the fee based on hardship, information to demonstrate that the patient is eligible for a hardship exemption;

(10) with respect to a patient who is not an insured and who submits a dispute for a surprise bill, a statement that the required disclosures have not been provided;

(11) an attestation affirming that the information provided by the patient is true and accurate; and

(12) any information requested by the IDRE.

(f) A patient shall not be required to pay the physician's, hospital's, or non-participating referred health care provider's fee in order to be eligible to submit the dispute for review to an IDRE.

(g) A health care plan, physician, hospital, non-participating referred health care provider or patient shall provide any information requested by an IDRE as soon as possible, but no later than the timeframe requested by the IDRE, as provided under 400.8 of this Part.

Subdivisions 400.8(a), (b), (c), (e), (h), (i), (j), and (k) are amended to read as follows:

(a) Within three business days of receipt of an application submitted by a health care plan, non-participating physician, non-participating hospital, non-participating referred health care provider or a patient, an IDRE shall screen the application for any conflicts of interest in accordance with section 400.4 of this Part. If the IDRE determines a conflict exists, the IDRE shall reject the application and return it to the superintendent within those three business days.

(b) If the IDRE determines that a conflict does not exist, the IDRE shall, within three business days of receiving an application submitted by a health care plan, non-participating physician, non-participating hospital, or non-participating referred health care provider:

(1) screen the application for eligibility;

(2) contact the health care plan, physician, hospital, or non-participating referred health care provider if additional information is needed to determine eligibility of the request for dispute resolution and provide the health care plan, the physician, hospital, or non-participating referred health care provider three business days to

submit the information and provide an explanation of where the information should be sent. If the information is not submitted, the IDRE shall make a second request and provide one business day to submit the information. If the information is not submitted, or if the application is not eligible, the IDRE shall promptly reject the application.

(c) Within three business days of a determination that the health care plan's, physician's, hospital's or nonparticipating referred health care provider's application is eligible, or within three business days of receipt of the patient's application from the superintendent, the IDRE shall send notification of the assignment to the health care plan, physician, hospital, non-participating referred health care provider and, for a patient initiated application, to the patient. The IDRE shall include in the notification:

(1) a request for the information specified in subdivisions (c), (d), and (e) of section 400.7 of this Part;

(2) a request for any additional information that may be available to support the appeal;

(3) an explanation of where the information should be sent;

(4) a statement that all information must be submitted within five business days of the notification;

(5) a statement that if a partial response or no response is received, the dispute will be decided based on the available information; and

(6) a statement that the IDRE shall not reconsider a dispute for which a determination has been made based upon receipt of additional information subsequent to such determination.

* * *

(e) If the IDRE determines, in a case involving a health care plan, based on the health care plan's payment or best and final offer, if applicable, and the non-participating physician's or non-participating referred health care provider's fee, or the non-participating hospital's fee or best and final offer, as applicable, that a settlement between the health care plan and the non-participating physician, non-participating hospital, or non-participating referred health care provider is reasonably likely, or that both the health care plan's payment or best and final offer, if applicable, and the non-participating physician's or non-participating referred health care provider's fee, or the non-participating hospital's fee or best and final offer, as applicable, represent unreasonable extremes, the IDRE may direct both parties to attempt a good faith negotiation for settlement. The health care plan and the non-participating physician, non-participating hospital, or non-participating referred health care provider may be granted up to ten business days for this negotiation, which shall run concurrently with the 30 day period for dispute resolution.

* * *

(h) For disputes involving a health care plan, in determining a reasonable fee for the services rendered, an IDRE shall select either the health care plan's payment, or in cases involving a non-participating hospital that had previously entered into a participating provider agreement with the health care plan, the health care plan's best and final offer, if applicable, or the non-participating physician's or [, as applicable, the] non-participating referred health care provider's fee, or the non-participating hospital's fee, or, in cases involving a non-participating

hospital that had previously entered into a participating provider agreement with the health care plan, the non-participating hospital's best and final offer, as applicable. For disputes that do not involve a health care plan, the IDRE shall determine a reasonable fee.

(i) An IDRE shall use the conditions and factors set forth in Financial Services Law section 604 when determining the reasonable fee and shall consider any other information submitted by the parties pursuant to subdivisions (c)(10), (d)(11), and (e)(7) of section 400.7 of this Part.

(j) An IDRE shall forward copies of the dispute resolution determination to the health care plan, physician, hospital, or non-participating referred health care provider, superintendent, and as applicable, patient, within two business days of rendering the determination. The notification shall include:

(1) the fee determined to be reasonable along with the reasons for the determination, including a discussion of the fee charged by the physician, hospital, or non-participating referred health care provider, or, as applicable, the non-participating hospital's best and final offer; the fee paid by the health care plan, or, in cases involving a non-participating hospital, the health care plan's best and final offer, if applicable; the usual and customary charge for disputes involving physician services; and other information provided;

(2) a statement attesting that no prohibited material affiliation existed with respect to the reviewer or reviewing physician;

(3) the biographies of the reviewer and the reviewing physician; and

(4) a request for payment to the party that does not prevail.

(k) An IDRE shall not divulge to the health care plan, physician, hospital, non-participating referred health care provider or patient the name of the reviewer or reviewing physician assigned to the dispute.

Subdivisions 400.10(a) and (b) are amended to read as follows:

(a) Disputes involving an insured.

(1) If an IDRE determines the health care plan's payment, or best and final offer, as applicable, is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician, non-participating hospital, or as applicable, nonparticipating referred health care provider.

(2) If an IDRE determines the non-participating physician's or non-participating referred health care provider's fee or the non-participating hospital's fee or best and final offer, as applicable, is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan.

(3) If good faith negotiations directed by the IDRE results in a settlement between the health care plan and the non-participating physician, non-participating hospital or non-participating referred health care provider, the health care plan and the non-participating physician, non-participating hospital or non-participating referred health care provider shall evenly divide and share the prorated cost for dispute resolution.

(4) For disputes that are rejected as ineligible or due to the requesting non-participating physician, non-participating hospital, nonparticipating referred health care provider or health care plan's failure to submit information, an IDRE may charge an application processing fee, which shall be the responsibility of the requesting physician, hospital, health care provider or health care plan.

(b) Disputes involving a patient who is not an insured.

(1) If an IDRE determines the physician's or hospital's fee is reasonable, payment for the independent dispute resolution process shall be the responsibility of the patient. If the superintendent determines that payment would pose a hardship to the patient pursuant to subdivision (c) of this section, the IDRE shall waive payment for the dispute resolution process.

(2) If an IDRE determines the physician's or hospital's fee is not reasonable, payment for the independent dispute resolution process shall be the responsibility of the physician or hospital.

NEW YORK STATE OF OPPORTUNITY. Department of Financial Services

ANDREW M. CUOMO
Governor

LINDA A. LACEWELL
Superintendent

CERTIFICATION

I, Linda A. Lacewell, Superintendent of Financial Services, do hereby certify that the foregoing is the First Amendment to Part 400 of Title 23 of the Official Compilation of Codes, Rules and Regulations of the State of New York, signed by me on June 23, 2021, pursuant to the authority granted by Sections 202, 301, 302, and Article 6 of the Financial Services Law, and Section 301 of the Insurance Law, to take effect 30 days after publication of the Notice of Adoption in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the revised proposed amendment was published in the New York State Register on April 7, 2021. Prior notice of the original proposed amendment was published in the New York State Register on October 23, 2020. No other publication or prior notice is required by statute.

Signed copy filed with Department of Financial Services
Linda A. Lacewell
Superintendent of Financial Services

Dated: June 23, 2021