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CLIENT ALERT

New York State Department of Financial Services Summarizes Changes Relating to Administrative Denials, Prior Authorizations, and Claims Payment

By Jackie Selby and Gregory R. Mitchell

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On March 10, 2021, the New York State Department of Financial Services ("DFS") issued Insurance Circular Letter No. 4 ("Circular Letter"),[1] which both explains modifications to the Insurance Law and the Public Health Law brought about by statutory changes in 2021 and sets forth two policy statements by DFS. More specifically, the Circular Letter summarizes a host of important statutory changes relating to common managed care issues, including administrative denials, utilization review, coding, and denials of pre-authorized services. In addition to covering statutory changes, the Circular Letter clarifies the DFS's positions on when down-coding requires a utilization review determination and on the subsequent denial of a claim that had received pre-authorization. These changes relate to commercial and Medicaid products in New York; they do *not* affect Medicare Advantage and self-funded plans governed by the Employee Retirement Income Security Act (or "ERISA"). All changes discussed in the Circular Letter apply to services performed on or after January 1, 2021.

The Circular Letter explains various changes to statutes that are generally friendly to providers, and particularly inpatient facilities. The clarifications of existing policies do not stake any new positions but do demonstrate areas in which DFS has taken an interest. Some of these changes, such as prohibitions on administrative denials, will have an immediate effect on payors and providers, and may play a role in future negotiations between payors and providers.

Prohibition on Administrative Denials in Inpatient Settings

In 2020, New York Insurance Law §§ 3217-b(j)(1) and 4325(k)(1) as well as Public Health Law § 4406-c(8)(a) were amended to prohibit insurers and managed care organizations ("MCOs") from denying payment by contract, written policy, or procedure, or by any other means, to a hospital for medically necessary inpatient services, observation services, and emergency department services solely for failure of the hospital to comply with

[1] The Circular Letter is available at https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_04.

administrative requirements. Hospitals and insurers/MCOs may still agree in contracts to administrative requirements, including timely notification by the hospital of the provision of medically necessary inpatient services, observation services, or emergency department services (in the same manner the statutes previously permitted provisions for timely notification for inpatient services resulting from an emergency department admission). Any timely notification requirement must, however, allow for "reasonable extensions of time" for services provided on weekends and federal holidays. The laws have also been revised to reduce the maximum penalty in the contract for failure to follow administrative requirements, including failure to timely notify the insurer/MCO, to 7.5 percent of the payment amount for services provided. There are exceptions in the applicable statutes to this requirement related to fraudulent or abusive billing practices, denials required by state or federal coverage, claims not submitted timely, duplicate claims, uncovered services, repeated failure of the hospital to obtain prior authorizations, claims for services for which prior authorization was denied, and requirements imposed by state or federal laws, rules, or regulations.

The Circular Letter also clarifies that a denial prompted by the hospital's failure to timely provide clinical documentation by a particular deadline is prohibited. However, denials for lack of medical necessity caused when clinical documentation has not been submitted are permitted.

Updates to Prompt Pay Law

In 2020, the New York Legislature made changes affecting the prompt pay statute, Insurance Law § 3224-a. Insurers and MCOs were previously required to pay all claims within 30 days (or 45 for paper claims) of the date the claim was submitted if the insurer's/MCO's obligation to pay was clear or within 30/45 days of the insurer's/MCO's determination that it had an obligation to pay if not immediately clear. The legislative changes add a new requirement—claims must be paid within 15 days of the determination that payment is due. This means that if the insurer's/MCO's obligation to pay is clear, it must pay the claim with 15 days, and in no case (except if additional information is necessary to make the determination) may payment be made later than 30 days following the submission of the claim (or 45 days if the claim is submitted on paper).

There are some other minor legislative changes to the prompt pay law:

- Written notice must be sent in the same manner as the claim was submitted (e.g., if the claim was filed electronically, notice must be given electronically).

- If an insurer/MCO denies a claim, the insurer/MCO must provide information with the denial identifying the specific plan or product in which the affected individual is enrolled.

- If an insurer/MCO re-codes a claim, a hospital may submit evidence supporting the original coding within 30 days of receipt of the adjudicated claim.

- Insurers/MCOs are subject to an interest penalty on late claims starting 30 days after the submission of an electronic claim, or 45 days following the submission of a paper

claim (interest previously began to accrue after 45 days regardless of the method of submission).

Updates Regarding Prior Authorizations and Appeal Timeframes

Finally, there are revisions to Insurance Law §§ 4903 and 4904 as well as Public Health Law §§ 4903 and 4904 relating to utilization review determinations. Insurers and MCOs are now required to make pre-authorization determinations for inpatient rehabilitation services following an inpatient admission by a hospital or skilled nursing facility within one business day from the receipt of necessary information. And insurers and MCOs are now required to make a determination on a standard (i.e., non-expedited) appeal within 30 days of receipt of information, down from 60 days. Upon the conclusion of the appeal, the insurer/MCO must also comply with the prompt-pay requirements.

DFS Clarification on Down-Coding and Denials Following Prior Authorizations

The Circular Letter goes on to address two common practices that DFS wishes to clarify its position on. The first issue relates to down-coding claims without a medical necessity review. The Circular Letter clarifies that down-coding because the submitted code was not consistent with the services actually provided does not require a "utilization review." However, determinations relating to (i) the clinical appropriateness of a treatment, (ii) whether the service was provided in compliance with generally accepted standards of care, (iii) whether the service was not primarily for the convenience of the insured, (iv) the relative cost of the service compared to alternatives, or (v) the setting of the service compared to alternative settings are "utilization review" determinations. DFS gives the example that a down-coding from an inpatient hospital service to an observation level of care or an outpatient basis because the lower level of care was medically appropriate are utilization review determinations subject to applicable law.

The second issue DFS addresses relates to retroactive denials of pre-authorized services. DFS explains that Insurance Law §§ 3228 and 4905 as well as Public Health Law § 4905 prohibit insurers and MCOs from subsequently denying a claim for a pre-authorized service unless the patient was not actually a covered person at the time of service, the claim was not timely submitted, the patient had exhausted a benefit limitation between the approval and the rendering of the service, the approval was based on incomplete or materially inaccurate information, or reasonable suspicion of fraud or abuse. Outside of those instances, and a few other minor exceptions explained in the cited statutes, a pre-authorized service may not subsequently be denied.

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This Client Alert was authored by **Jackie Selby** *and* **Gregory R. Mitchell.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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