New York Department of Financial Services

Consumer Assistance Unit ("CAU")

November 15, 2022

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Services Provided by CAU

- Consumer Complaints
- Provider Complaints
- Legislative Complaints Filed on Behalf of Constituents
- Screening of External Appeal Applications
- Assisting with questions from Consumers & Providers received by phone or email.

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DFS' Jurisdiction

- DFS has jurisdiction over issues related to health insurance policies situs in the state of New York.
- DFS does NOT have jurisdiction over issues related to the following types of coverage:
  - Self-funded plans
  - Medicare or Medicare HMO policies
  - Out-of-State contracts
  - Federal Employee plans
  - Essential Plans (except for External Appeals & Independent Dispute Resolutions)

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Most Common Types of Complaints Received from Providers

- Delay in payment of claim
- Dispute on amount of payment on claim.
- Interpretation of patient's policy provisions (Administrative/Contractual Denials)
- Timely filing denial
- Claim Payment Recoupment
- Medical Necessity denial

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Types of Complaints DFS Can Not Assist With

- Participating provider contract issues
- Medicaid enrollment issues
- Timely Filing disputes
- DRG adjustments or disputes

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Prior Authorization

- Section 3238 of the NYS Insurance Law
- Insurer shall pay claims for health care services for which pre-authorization was required by and received from the health plan prior to the services being rendered.
- But there are exceptions…..

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Prior Authorization (Cont.)

The health plan is not required to issue payment on pre-authorized services in the following circumstances:

- The patient was not a covered enrollee at time services were rendered.
    - Health plan, however, may not deny claim if patient's coverage retroactively denied more than 120 days after the date of service; and claim submitted within 90 days after date of service.
    - If claim submitted after 90 days after date of service, health plan then has 30 days from receipt of claim to deny claim on the basis that insured was not enrolled at time of service.

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Prior Authorization (Cont.)

The health plan is not required to issue payment on pre-authorized services in the following circumstances (continued):

- Claim form is not submitted timely.
- At time of pre-authorization policy benefit limitations had not been exhausted but benefit limits were subsequently exhausted after authorization was issued.
- Pre-authorization was based on materially inaccurate or incomplete information and if correct or complete information was known pre-authorization would not have been granted.

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Prior Authorization (Cont.)

The health plan is not required to issue payment on pre-authorized services in the following circumstances (continued):

- Reasonable basis that patient, patient's designee, or provider has engaged in fraud or abuse.
- Health plan not prohibited from denying continued or extended coverage as part of a concurrent review of services.
- Other insurance coverage exists at time of service that is primary.
- Provider contract may have additional provisions.

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Utilization Review

Topics to be discussed:

- What is Utilization Review (UR)?
- Types of UR
- Determination Time frame
- Internal Appeal
- External Appeal

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Utilization Review (cont.)

What is Utilization Review?

A review of health services to determine whether the services are:

- Not medically necessary or
- experimental/investigational or
- a clinical trial, a treatment for a rare disease or
- a step therapy protocol override for a prescription drug.

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Utilization Review (cont.)

Types of Utilization Review

- Pre-Authorization review- Takes place prior to service being performed.
- Concurrent review- Takes place when service is being performed.
- Retrospective review-Takes place after the service is performed.

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Utilization Review (cont.)

Determination Time frame for Initial UR – Pre-Authorization

Standard:

- If request includes all information needed, a determination is made, and notice is provided by telephone and in writing within three (3) business day of receipt of request.
- If additional information needed:
  - Health plan requests additional information within 3 business days of request.
  - Provider has 45 days to submit additional information.

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Utilization Review (cont.)

- If information is received within 45 days, determination is made, and notice provided by telephone and in writing within 3 business days of receipt of the additional information.
- If information not received within 45 days, determination is made within 15 calendar days from earlier of:
  - Receipt of partial information requested;
  - or the end of the 45-day period.

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Utilization Review (cont.)

Determination Time frame for Initial UR – Pre-Authorization

Expedited:

- If request includes all information needed, determination made, and notification provided by telephone within 72 hours of the request. Written notice of determination provided within 3 business days of receipt of request.
- If additional information needed:
  - Health plan requests it within 24 hours of receipt of request.

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Utilization Review (cont.)

- Provider has 48 hours to submit information.
- Health plan will provide notice of to provider by telephone, and in writing if applicable under policy, within 48 hours of the earlier of:
  - Receipt of the information; or
  - End of the 48 hours in which additional information was required to be submitted.

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Utilization Review (cont.)

Determination Time frame for Initial UR – Concurrent

Standard:

- If health plan has all necessary information, determination made, and notice provided by telephone and in writing within 1 business day of receipt of the request.
- If additional information needed:
  - Health plan requests additional information within 1 business day of receipt of request.
  - Provider has 45 days to submit additional information.

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Utilization Review (cont.)

- Determination made and notice provided at the earlier of the following:
  - Within 1 business day of receipt of the additional information;
  - Within 15 calendar days of receipt of partial information; or
  - 15 calendar days after the end of the 45-day period if no information is received.

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Utilization Review (cont.)

Determination Time frame for Initial UR– Concurrent

Expedited:

- If request for an extension of urgent care is made at least 24 hours prior to expiration of previously approved treatment:
  - Determination made and notice provided by telephone within 24 hours of receipt of the request.
  - Written notice will be provided within 1 business day of receipt of the request.

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Utilization Review (cont.)

- If request for an extension of urgent care is made less than 24 hours prior to expiration of previously approved treatment:
  - Determination made, and written notice provided within the earlier of 72 hours or one (1) business day of receipt of the request if health plan has all necessary information.
  - If additional information needed:
    - Health plan requests additional information within 24 hours of receipt of request.
    - Provider has 48 hours to submit information.

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Utilization Review (cont.)

- Determination made and written notice provided within the earlier of:
  - one (1) business day or 48 hours of receipt of the information or,
  - Within 48 hours of the end of the 48-hour period if the information was not received.

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Utilization Review (cont.)

Determination Time frame for Initial UR – Retrospective

- If health plan has all necessary information, determination made, and notice provided within 30 calendar days of receipt of the request.
- If additional information needed:
  - Health plan requests additional information within 30 calendar days of receipt of request.
  - Provider has 45 calendar days to submit requested information.

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Utilization Review (cont.)

- Determination made and written notice provided within 15 calendar days of the earlier of:
  - Receipt of all or part of the requested information; or
  - The end of the 45-day period.

❖ Retrospective services are not eligible for expedited UR

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Utilization Review (cont.)

Internal Appeals - Who can file & The time frame

Within no less than 45 days of receipt of an initial UR adverse determination:

- An insured or insured' designee can file an internal appeal with health plan for Pre-authorization, Concurrent and retrospective adverse determinations. For policies subject to ERISA, the insured or the insured's designee has up to 180 days to file an internal appeal.
- Providers can only file an internal appeal on their own behalf for retrospective adverse determinations.
- Internal appeal will be conducted by a different clinical peer reviewer other than who rendered the UR adverse determination.

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Utilization Review (cont.)

UR (Internal) Appeal Determination Time Frame

- **Standard appeal** - within thirty (30) days of the receipt of necessary information.
- **Expedited appeal** - within the earlier of 72 hrs. or two (2) business days of receipt of necessary information.
  - ➢ Under Article 4904(e) of NYS Insurance Law, failure to make the determination on internal appeal within the required time frame deemed to be a reversal of UR agent adverse determination.
  - ➢ If plan upheld the appeal, a **Final Adverse Determination (FAD)** letter with NYS External Appeal rights will be issued.

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External Appeal ("EA") with NYSDFS

- Providers/hospitals or their designees have the right to file EA within 60 days of FAD only for concurrent and retrospective adverse determinations.
- Insureds and their designees have the right to file EA within 4 months of FAD for pre-service, concurrent and retrospective and adverse determinations.
- EA can be filed online or downloading an application by visiting https://www.dfs.ny.gov/complaints/file_external_appeal or calling us at 1-800-400-8882.

❖ **Medical records should NOT be submitted to DFS. Wait until the EA is assigned to an agent and then send directly to the agent.**

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External Appeal ("EA") with NYSDFS (cont.)

Time frame for EA decision once assigned to an agent:

- Standard review- 30 days
- Expedited review – 72 hrs.

Time frame for Formulary Exception EA decision once assigned to an agent:

- Standard review- 72 hrs.
- Expedited review – 24 hrs.

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Recoupment of payments made to providers

- Section 3224-b permits insurers to "clawback" overpayments made to healthcare providers
- Recoupment cannot take place more than 24 months after the original payment, except where:
  - There's a reasonable belief of fraud, intentional misconduct or abusive billing
  - Required by, or initiated at the request of, a self-insured plan
  - Required or authorized by the state or municipality

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Recoupment of payments made to providers (cont.)

Plan must provide 30-days written notice before making recovery efforts, which must include:

- Name of the patient
- Date of service
- Payment amount
- Amount of the proposed adjustment
- A reasonably specific explanation for the adjustment
- The opportunity for the provider to challenge the adjustment

❖ Notice is NOT required for recovery of duplicate payments.

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How to File a Complaint

- Go to www.dfs.ny.gov
- Click on “File A Complaint” and then “DFS portal” under “Healthcare Provider Complaint.
- Create a Portal Account to file Prompt Pay, No-Fault, or Workers’ Compensation complaints.
- Group complaints by carrier and patient for data entry purposes; one complaint per patient listing all dates of service in question.
- Enter patient info, dates of service (use admission date for inpatient stays), CPT code (“00000” for hospital stays).
- Complaint must include a description of the problem. Otherwise, DFS will not know if the company provided a substantive response.

❖See separate instructions for further details on filing a complaint.

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Disputing Insurer's Response to Complaint

What can you do if you disagree with the health plan's response to your complaint?

- Contact the insurer directly
- Write to the Financial Services Examiner assigned to the complaint with details.
- Provide documentation in support of your argument.

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Q & A

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Contact Information

- The DFS Hotline is staffed Monday - Friday, from 8:30 AM to 4:30 PM. Call us at (800) 342-3736 or send us an email at consumers@dfs.ny.gov.
- File a complaint at: https://www.dfs.ny.gov/complaint
- File an External Appeal at: https://www.dfs.ny.gov/complaints/file_external_appeal
- By Mail at:

  New York State Department of Financial Services
  Attn: Consumer Services Unit
  1 Commerce Plaza
  Albany, NY 12257

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