



*Dedicated to protecting access to quality healthcare for automobile accident victims*

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Last month the Insurance Department released the latest version of proposed changes to the regulations governing the payment of No-Fault benefits. Throughout the revision process the Department solicited comments from the Insurance Industry, medical community and attorneys representing accident victims and medical providers.

In response to previous versions, our membership submitted lengthy and detailed comments. A number of our recommendations were adopted and are reflected in the latest proposal, however, the latest version still contains a large number of harsh, unfair provisions that benefit insurers at the expense of accident victims and their health care providers.

Our review of the proposed changes revealed the following items of great concern. If you share our concerns, let the Department know before the **April 20, 2011 deadline**. Comments should be emailed to the department at [Reg@ins.state.ny.us](mailto:Reg@ins.state.ny.us) or submitted via the online form at [http://www.ins.state.ny.us/r68/r68\\_draft\\_form.htm](http://www.ins.state.ny.us/r68/r68_draft_form.htm). It also would be helpful for you to cc your comments to us at [info@newyorkfair.org](mailto:info@newyorkfair.org)

**Documentary Proof of Medical Necessity** Each and every bill must be submitted with “documentary proof of the necessity of the treatment” within 45 days of the first date of service. This requirement applies to each procedure and each date of service. No other medical reimbursement framework imposes such an onerous requirement on the initial submission. Furthermore, this requirement will only lead to more conflict as opportunistic insurers will argue whatever proof was submitted was insufficient to actually prove the services were necessary. Finally, it is unclear whether the provider will ever be able to supplement the initial documentation submitted, essentially requiring the provider to meet the insurer’s unilateral standard of medical necessity within 45 days or lose its claim forever. This amounts to a system of pre-approval, which certainly was not contemplated by the No-Fault laws.

**A Diagnosis Code For Each Service Provided** The new NF-3 requires a diagnosis code for each procedure for each date of service. The requirement that each procedure or date of service contain a diagnosis code should be removed.

**“Drop-Dead” Deadline For Responding To Requests For Information** Claims can be denied if requested information or documents in the patient’s or the health care provider’s possession are not produced within 180 days. The only exception to this deadline is for “inability” to respond in a timely manner. The fact that the person may have thought it had a good reason for not responding (like the demand was unreasonable, or requested

personal or confidential information) is irrelevant. It is also irrelevant that the insurer suffered no prejudice from a belated response. We think that 11 NYCRR 65-3.5(e) should be changed so that the “failure” to respond in a timely manner should be excused if there is a good reason for the “failure” (not inability), or if the carrier did not suffer any prejudice from the late response.

**No Notice to Attorneys** Under the current regulation, the insurer must notify the applicant and the applicant’s attorney if requested information is not provided. Under the latest version, the attorney notification requirement has been deleted. Indeed there is no requirement that the insurer ever notify the accident victim or the health care provider’s attorney. There should be a specific rule that where an insurer knows that someone is represented by an attorney, notices must be sent to both the person, and that person’s attorney. This is especially important in light of the 180 day drop-dead deadline.

**Licensure Examination Under Oath** The most objectionable aspect of the proposed regulations—and the one most likely to discourage legitimate health professionals from treating accident victims—is the manner in which the regulations authorize insurers, without any prior approval from any governmental agency, to unilaterally suspend all payments for services rendered merely by demanding a “licensure” examination under oath.

**Expedited Arbitration for Abusive EUO or Verification Requests** We are concerned that the institution of strict deadlines for compliance with insurers’ demand for documents and Examinations Under Oath will encourage opportunistic insurers to utilize these tools to avoid the payment of legitimate claims. There should be some forum established (like expedited arbitration) where an accident victim or provider can get an expedited ruling on such demand without the risk that the entire claim will be denied.

**Multiple Licensure Examinations Under Oath** The Departments initial proposal limited each insurer (all 457 of them) to one licensure EUO per insurer per provider unless the insurer had a “well founded and articulable belief that there has been a change in such status since the previous examination under oath.”

Under this new proposal, the insurer may conduct multiple licensure reviews of a single assignee if the insurer has a “reasonable belief that new facts emerged concerning the assignee.” This standard is so vague as to be meaningless. What is a “reasonable belief that new facts emerged?” New facts “emerge” every day simply by the passage of time. An insurer seeking to hold a multiple licensure review of a single assignee should have to meet a very high threshold. If there is concern that the first proposed standard required a change in the licensure status, as opposed to a change in what was known about the licensure status, such would be more properly addressed with the following language:

Insurers or any member for their group, subsidiary, or related company, may not conduct more than one licensure examination under oath of a particular assignee unless there exists a well-founded and articulable belief of newly discovered compelling facts clearly indicating that the assignee is not in compliance with state or local licensing

laws and those fact were not known or knowable at the time of the first examination, or there has been a material change in the licensing status since the prior licensure examination under oath.

**Confusing Compliance With Policy Conditions With Coverage** The new proposal adds the following language to the insurance contract:

The failure of an applicant to comply fully with the terms of this coverage shall be deemed a breach of a condition precedent to coverage for the applicant and the applicant's assignee....and....be deemed a breach of a condition precedent to coverage, but shall only implicate coverage for claims submitted by that assignee.

Such confuses the failure to comply with a condition of the policy, with a complete voiding of coverage. Coverage consistently means the availability of insurance for the underlying accident. It does not have anything to do with the payment of a particular bill. For example, it is a condition of the policy that bills be submitted within 45 days, and the failure to submit a particular bill in 45 days may result in the bill being properly denied, and deprive the assignee of the right to payment, but it cannot be said that the failure to submit a bill on time will void coverage for the entire accident necessarily implied by the language: shall be deemed a breach of a condition precedent to coverage.

**Objections at Examinations Under Oath** This version of the proposed regulations provide "A legal representative of an applicant or assignee may state an objection to the scope or relevance of questions directed to the person being examined;" This necessarily implies that objections are limited to "scope or relevance." There should be no such limitation. There is little justification for permitting an objection as to scope or relevance, but prohibit other lawful objections such as: asked and answered, leading, vague, compound, confusing questions, questions that call for the disclosure of privileged information, questions that call for speculation, or for information about which the deponent is incompetent, or information that is protected as attorney work product.

**Alteration of Peer Reviews and Medical Examination Reports** Previous proposals from the Department prohibited the alteration or modification of such reports. This latest proposal permits the modification of the reports prior to their being signed. Such reports should be generated exclusively by the healthcare professional whose name appears on the report.

THE DEADLINE TO SUBMIT COMMENTS IS **APRIL 20, 2011.** THE NUMBER AND QUALITY OF COMMENTS SUBMITTED ABSOLUTELY HAS AN AFFECT ON THE FINAL VERSION OF THE REGULATIONS. EMAIL YOUR COMMENTS TO [Reg@ins.state.ny.us](mailto:Reg@ins.state.ny.us) OR SUBMIT THEM ONLINE AT [http://www.ins.state.ny.us/r68/r68\\_draft\\_form.htm](http://www.ins.state.ny.us/r68/r68_draft_form.htm).