NEW YORKERS FOR FAIR AUTOMOBILE INSURANCE REFORM • NYFAIR

Dedicated to protecting access to quality healthcare for automobile accident victims

April 20, 2011

Honorable James J. Wrynn
Superintendent of Insurance
New York State Insurance Department
25 Beaver Street
New York, NY 10004

Lawrence M. Fuchsberg, Esq.
Principal Attorney
New York State Insurance Department
25 Beaver Street
New York, NY 10004

Re: Comments to Working Draft of Revision to No-Fault Regulation 68

Dear Sirs:

New Yorkers for Fair Automobile Insurance Reform "NYFAIR" extends its sincere gratitude for the opportunity to comment on the latest Working Draft of the Revisions to No-Fault Regulation 68. We recognize that the latest Working Draft is the product of great effort on the part of the Department of Insurance. In the following pages, we provide a detailed commentary on the Working Draft, paying special attention to our gravest concerns. We hope that you find our insight helpful as the Department finalizes the Revision.

NYFAIR is a collection of concerned individuals, businesses, and organizations dedicated to ensuring New Yorkers have continued access to the medical treatment they need after automobile accidents. Many of our members are health care providers that treat accident victims, and the attorneys that assist them in obtaining overdue benefits. Together, NYFAIR's members represent the interest of thousands of healthcare professionals in the state of New York. As such, NYFAIR possesses unique insight

11 GRACE AVENUE, SUITE 111 • GREAT NECK, NY 11021
TEL. 516-829-0363 • FAX. 516-829-0366
INFO@NEWYORKFAIR.ORG • WWW.NEWYORKFAIR.ORG
STUART M. ISRAEL, PRESIDENT

regarding the practical effect the proposed changes would have to healthcare providers if left uncorrected.

At the outset, we wish to recognize the broad authority the Department has to enact regulations implementing the No-Fault law. We also recognize the difficulty balancing the need to regulate large profit driven financial institutions against the desire to prevent abuse by those seeking benefits. However, we urge the Department to remember that, at its heart, the No-Fault law is a consumer reparations statute. In a very real sense, the Regulations the Department implements will effect the availability of health care benefits for tens of thousand of New Yorkers, many of whom do not have the advantage of general medical insurance. For many poor and middle class New York families, the denial of No-Fault benefits means the denial of treatment for injuries sustained in the underlying accident.

The viability of the No-Fault system depends upon the willingness of a large number of quality healthcare providers to provide treatment with the expectation that they will be fairly compensated. We are concerned that many of the recently proposed changes will restrict accident victim's access to medical case and decrease the ability of doctors and other health care providers to provide services due to the increased administrative costs and uncertainty of reimbursement.

Many of the concerns raised by the Insurance Industry, while legitimate, are exaggerated. For example, one industry-funded source claims that no fault fraud cost New Yorkers $241 million in 2010 and $229 million in 2009. However, the Insurance Department 2009 annual report reveals that there were a total of 13,433 questionable claims, and the average no-fault claim cost was $8,690. Assuming $8,690 was the average cost of a no-fault claim, and there were 13,433 suspected cases of fraudulent claims (a liberal estimate since they're merely suspected, not proven), the cost of no-fault fraud in 2009 was approximately $116 million; a far cry from the $229 million asserted by the Industry.

Moreover, while $116 million in suspected no-fault fraud sounds like a large amount, consider that in 2009 New York's auto insurers collected $9.9 billion in premiums from New Yorkers. Therefore, suspected fraud accounts for less than 1.2% of premium dollars. Even if all the suspected fraud was eliminated, and carriers passed nearly all the savings to their customers, premiums would decline merely 1%.

In short, overreacting to insurers' demands risks causing greater problems than the proposed changes are intended to resolve. We urge a cautious approach.

Significantly, the Insurance Law requires insurers to report suspected fraud to the Frauds Bureau, and such requirement accounts for the relatively large number of reports. Insurers suspect a claim to be fraudulent if (1) the accident occurs within the first 60 days of the policy inception; (2) involves a late model car; (3) involves a sideswipe collision; (4) involves a "hit and run" accident; or, (5) involves a person with prior accidents. Any one of these factors could be completely innocent, yet insurers' internal guidelines mandate that the presence of any of these factors results in a "report of suspected fraud."

Department spokesman Ron Klug concedes that some suspected fraud cases are (1) later deemed unfounded; (2) addressed by other agencies; (3) may not be worth prosecuting; or, (4) may result from multiple referrals concerning a single event. Each of these instances result in further exaggeration of the insurers "fraud" numbers. Likewise, while the law requires the insurer to report suspected fraud, it does not require any curative filing when the carrier's suspicions are ultimately determined as unfounded.

Importantly, the New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association-- both industry funded organizations-- initiated a massive multi-media advertising campaign using newspapers, radio and television to urge consumers to report possible fraud. As a result of these programs, New Yorkers were flooded with anti-fraud messages, which focused on the alleged cost and frequency of insurance fraud and urged the public to assist in preventing fraud. Because the Fraud Bureau calculates the prevalence of no-fault fraud based on suspected reports, it reasonably follows that encouraging the public to get involved (and facilitating their involvement with a hotline number and website) would greatly increase the number of suspected fraud reports. However, the number of suspected fraud reports actually decreased approximately 5% in 2010. Despite the subject multi-million dollar media campaign, there were 626 fewer cases of suspected fraud reported in 2010 than in 2009 (13,433 cases in 2009, 12,807 cases in 2010).

Indeed, of the entire universe of 12,807 suspected fraud reports, only 170 new health care fraud cases were opened in 2010 (resulting in only 159 arrests). This strongly suggests that the vast majority of reports of suspected fraud are later determined to be unfounded

Another example of insurer exaggeration concerns the existing claim verification protocols. Based upon anecdotal evidence of a relatively small number of instances where insurers receive responses to verification requests years later, the Department has adopted a rule that jeopardizes tens of thousands of claims: Complete forfeiture of a paid for benefit based on the failure to comply in a timely manner with any demand that an insurer may make. In contrast with the failure to comply in a timely manner to a clearly defined statutory provision, insurers' verification demands (for documents, information, or examinations) are not subject to any clearly defined limitations, are not reviewed by a neutral party before the time for compliance expires, and forfeiture occurs regardless of whether the delay caused any prejudice to the insurer.

A well functioning responsible government cannot appropriately enact a system where large corporations are not accountable for their actions. Accountability includes the ability to challenge abusive demands (for verification or examinations under oath) and the improper withholding of payment, without fear that such challenge will not itself result in the forfeiture of benefits. Direct Department oversight is insufficient to protect the public. Market conduct studies are lengthy, expensive, and do not provide relief to those directly injured by improper conduct. Complaints to the Department are frequently unresolved as the Department feels that it cannot make factual determinations. The individual accident victims and the provider assignee must be given some mechanism

where a neutral responsible fact finder can decide whether an insurer has a good reason for requesting the information.

The Regulations the Department enacts will have a very real effect on the ability of accident victims to obtain health care. A solo practitioner in a suburb of Buffalo, who has to take a day off appear at an examination under oath, is unable to care for his patients. A general practitioner in Brentwood cannot afford to provide treatment to automobile accident victims if doing so will require an entire re-tooling of his office procedure simple to accommodate the demands of the No-Fault regulations and casualty insurers.

We have seen instances where in order to "verify" a single bill a carrier has insisted on a two-day 13 hour examination under oath where, after the doctor responded substantively to virtually every question posed, the insurer insisted on a third day of questioning purportedly to verify a single bill for a $49.26 follow-up visit even though that bill had already been paid. During the two days of testimony the entire discussion concerning the medical necessity of the unpaid bill amounted to approximately 30 pages of the 494 page transcript, or merely 6% of the entire examination. The examiner required the doctor to define virtually every medical term set forth in this report and discuss the medicine attendant to every condition or term referenced in the report (e.g. "Do you know what [bar electrodes are] made out of?"; "What does hypoesthesia mean?"; "What is the definition of a disc bulge?"; "Now, you described to me what an arthrodial protractor was. Describe for me what a goniometer is.").

The examiner demanded information regarding each and every underlying medical aspect of the treatment and evaluation of the patient, as if the doctor was required to educate the examiner on how to perform the procedure himself (e.g. regarding testing hand strength manually, "How are you so reliable that you can do that?"; "Can you give me the anatomy of a disk itself?"; demanded an "exhaustive list" of all the ways a physician can separate weakness of the ulnar innervated from the median innervated intrinsic muscles; even though the patient was 28 years old at the time, "Would it be common for the Achilles reflex to be less than the patella reflex in an older person?"; demanded that the doctor recite "clinical situations or conditions" where a diagnosis of "medical condition meralgia paresthetica" might be made, even though there was no indication that the patient suffered from such a condition).

These abuses are not limited to examinations under oath. The inclusion of the 180-day deadline makes it more imperative that the Department provide a dispute resolution process, such as expedited arbitration, where an applicant or assignee can obtain an impartial ruling on abusive requests without fear that merely requesting such ruling will result in forfeiture of the claim. Our members are currently besieged with hundreds of burdensome verification requests demanding:

- All documents related to the income and expenses of the PC, including but not limited to tax returns and general ledgers of the PC for the past 12 months.

- A list of all the individuals who provided and/or supervised the health care services for which you seek payment, identification of the type of profession license each individual holds and documents (i.e., W-2 1099, etc) identifying the relationship between the individual and the P.C. (e.g. whether the individual is an employee or independent contractor and how that individual is compensated),

- All documents, including schedules, attachments or addenda, related to the relationship between the P.C. and/or any entity or individual that leases equipment or space to or from the P.C. or provides management, consulting, administrative or billing services to the P.C. and any payment made to any person or entity that rendered such services to the P.C.

- All bank statements from the time of incorporation to the present.

- The corporations Quarterly Federal Tax Return form 941.

- Corporate tax returns.

- Personal tax returns.

- The make model and serial number of every piece of equipment that might have been used to treat or evaluate the applicant

- Employment agreements.

- Partnership agreements.

- All Equipment maintenance contracts.

The Regulations do not require insurers to seek prior approval before they make such onerous and improper demands. Indeed they reward such conduct by providing that the making of the demand tolls the time for payment of the claim.

We appreciate the legitimate policy goals of weeding out and denying reimbursement to providers who willfully and materially violate licensing laws. By the same token, many in the insurance industry have admitted privately that there needs to be clearly established rules governing insurer licensure reviews. The current environment has been characterized as “the wild west” where no one knows what the rules are.

In the following pages we provide commentary and attempt to suggest appropriate solutions that balance the need to prevent abuse by those seeking to game the system against the very real possibility that the proposed changes will allow insurers to perpetrate an even greater wrong. Encouraging financially motivated insurers to withhold payments for legitimate claims will simply drive health care providers out of the system leaving injured patients nowhere to turn for treatment and rehabilitation.

Revised Section:

Throughout

Revised Text:

Those regulations that require notice be sent to the applicant or assignee.

Comment:

The revised regulations provide insurers with new and amplified rights and remedies against consumers and medical providers. At the same time, the revisions strike language from the current regulations that require insurers to give notice to the applicant's or assignee's representatives and attorneys.

There should be a specific rule that where an insurer knows someone is represented by an attorney, that notices must be sent to both the person, and that person's attorney. This is especially important in light of the automatic claim forfeiture provisions requiring the production of requested information within 180 days, or after a re-scheduled examination "no-show."

The regulations should be specifically worded to deter unfair or abusive conduct. A clearly worded requirement will be much more effective at deterring unwanted conduct, than any subsequent individual intervention by the Department. We are concerned that many carrier's will simply refuse to notify counsel in the absence of the specific requirement that notices must be sent to the applicant or assignee, and their legal representative. For example, the even though 11 NYCRR 65-3.2(f) requires insurers to "Respond promptly, when a response is indicated, to all communications from insured, applicant or attorneys and any other interested persons," the response is often nothing more than a refusal to provide relevant information. One of the largest insurers routinely responds to requests for the status of unpaid overdue claims with a blatant refusal to comply coupled with a demand that further inquiries not be made.

Currently, even though many providers designate that all communications should be sent to the address of its legal representative, carrier's disregard this directive and send verification requests to the location where the services were rendered which often is not the location best suited to respond to the request. 11 NYCRR 65-3.4(a) affords the insurers additional time to respond to a noticed received "at an address other than the proper claims processing office…" Similarly, 11 NYCRR 65-3.5(b)(2) grants insurer an extension of up to 14 days, this section provides

> If a claim is received by an insurer at an address other than the proper claims processing office, the 21 calendar day period for requesting other verification shall commence on the date the claim is received at the proper claims

processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 14 calendar days after receipt at the incorrect office.

The Regulations grant no such allowance for health service providers. In contrast to the insurers, they have no such power to designate an agent for handling their claims. This is just one of the many instances where these proposed regulations appear tailored to serve the interests of the insurers, over those seeking benefits.

The following language is suggested (Our suggestions in bold throughout):

> **Where correspondence is required to be sent to any party, and the insurer has received written notice that such party is represented by counsel, the insurer shall also send a copy of such correspondence to that party's attorney.**

Revised Section:

§65-1.1- Other Definitions (i)

Revised Text:

(i) "no-show" means the failure of an applicant or assignee to appear for a scheduled health service examination or an examination under oath except when adjourned by the insurer.

Comment:

The inclusion of the phrase "except when adjourned by the insurer" implies that the adjournment must be at the request of the insurer.

Furthermore, some insurer are over-scheduling examinations to such an extent that even though the party appears for the examination, it is spontaneously adjourned, not at the request of the applicant or assignee, but of the insurer that demanded the examination. To prevent this abuse, we suggest the following

(i) "no-show" means the failure of an applicant or assignee to appear for a scheduled health service examination or an examination under oath except when adjourned by the insurer **at the request of the applicant or assingee.**

Revised Section:

§65-1.1- Conditions

Revised Text:

Conditions

Action Against Company. _- No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage. 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 assignees. The failure of an assignee to comply fully with the terms of this coverage shall be deemed a breach of a condition precedent to coverage, but shall only implicate coverage for claims submitted by that assignee.

Comment:

The added text, perhaps inadvertently, 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. See General Hospital v. Chubb Insurance Group of Insurance Companies, 90 N.Y.2d 195, 659 N.Y.S.2d 249 [1997] 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.

We suggest the following language to preserve the existing distinction between breaches of policy conditions and situations for which there is no coverage:

Action Against Company. _- No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage. 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 assignees. The failure of an assignee to comply fully with the terms ~~**of this coverage**~~ shall be deemed a breach of a condition ~~**precedent to coverage**~~, but shall ~~**only implicate coverage for claims submitted by that assignee.**~~ **not effect the rights of the applicant**.

Revised Section:

§65-1.1- Notice

Revised Text:

Notice. In the event of an accident, written notice setting forth details sufficient to identify the ~~eligible injured person~~ applicant, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by, or on behalf of, each ~~eligible injured person~~ applicant, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the ~~eligible injured person~~ applicant submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. If an ~~eligible injured person~~ applicant or that person's legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the Company or any of the Company's authorized agents by such ~~eligible injured person~~ applicant or that person's legal representative.

Comment:

Use of the language, **"**[U]nless the ~~eligible injured person~~ applicant submits written proof," is objectionable for several reasons. The literal reading of the section unreasonably restricts from whom written proof of justification of tardiness may come. Specifically stating that the proof must come from the applicant forecloses the very real possibility that such proof may need to come from someone acting on the applicant's behalf, such as a parent, guardian, or attorney. This restriction is even more irrational when one considers that the Notice required by this section *may* be provided by someone acting "on behalf of" the applicant. There seems no good reason to allow the Notice to be provided by someone acting on behalf of the applicant, but then preclude such representative from providing an excuse for tardiness. Moreover, the standard, "submits written proof providing a clear and reasonable justification," as a practical matter, is frequently a very difficult standard to meet. For example, the word "proof" is ambiguous and in real world application leads to disputes between applicants and insurers as to the "form" of such excuse, rather than the "substance" of the excuse. Counsel will frequently argue that the word "proof" suggest that the evidence must be made under oath, or in a form admissible in a court of law. Finally, requiring the justification to be "clear and reasonable" leads to disputes as to the meaning of the word "clear," rather than the merits of the excuse. Requiring the excuse to be "reasonable" – a term that both lay persons and attorneys are familiar with – is a sufficient safeguard to protect against potential

abuses by applicants, while also providing an unambiguous standard which must be met. As such, the Coalition proposes the following language be used:

> "Notice. In the event of an accident, written notice setting forth details sufficient to identify the ~~eligible injured person~~ applicant, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by, or on behalf of, each ~~eligible injured person~~ applicant, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the ~~eligible injured person~~ **applicant, or someone acting on the applicant's behalf,** submits ~~**a**~~ written **explanation** ~~**proof**~~ providing ~~**clear and**~~ **a** reasonable justification for the failure to comply with such time limitation. If an ~~eligible injured person~~ applicant or that person's legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the Company or any of the Company's authorized agents by such ~~eligible injured person~~ applicant or that person's legal representative."

Revised Section:

§65-1.1- Conditions

Revised Text:

Conditions

Proof of Claim~~;. Medical~~Health Service, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the ~~eligible injured person~~applicant or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, and documentary proof of the necessity of the treatment, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. ~~The~~ ~~eligible injured person~~applicant or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the

work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the ~~eligible injured person~~applicant or assignee submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. Upon request by the Company, the ~~eligible injured person~~applicant or that person's assignee or representative shall:

Comment:

The inclusion of the language "and documentary proof of the necessity of the treatment," requires each and every bill to be submitted with "documentary proof of the necessity of the treatment" within 45 days of the first date of service covered by that bill. 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. 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. 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.

The oft-stated purpose of the No-Fault law was to ensure prompt reimbursement for non-economic injury, including the payment for health care services. Requiring "documentary proof of the necessity of the treatment" within 45 days essentially creates a presumption that the services are unnecessary, requiring the production vaguely of defined "documentary proof" even where such necessity is not disputed. The insurers claims that they need such a provision are vastly exaggerated. In an environment where half of all claims are processed without any requests for additional verification, the Department has chosen to burden every provider, every time, with the burden of providing documentation that may not be needed or even reviewed. This provision is antithetical to the entire purpose of the No-Fault law.

It is arbitrary and capricious to saddle the health service provider with such a burden in the absence of any similar burden on the insurer. The insurer is under no such burden to provide documentary proof of the validity of its refusal to make payment.

Finally, this provision imposes yet another unique "no-fault rule" that applies to no other system of reimbursement. As such, it disproportionately penalizes those providers that have only a small portion of their practice dedicated towards the treatment of automobile victims, and encourages them to turn away those patients. We submit that this provision is not only unlawful, it is also bad policy.

Revised Section:

§65-3.2(c)

Revised Text:

(c) Do not demand verification of facts unless there are good reasons to do so. _ When verification of facts is necessary, it should be done as expeditiously as possible. An insurer shall not request an examination under oath unless it has requested verification by other means and still requires an examination under oath.

Comment:

The phrase "still requires" implies that the intent from the outset was a demand for an examination under oath and that request for verification is merely a procedural hurdle that may be overcome with a *pro forma* request for verification in some other form.

While we recognize that examinations under oath may ultimately be required in some instances, we strongly believe that such a burdensome demand should only be employed when the insurer has good cause, and after the insurer has been unable to obtain whatever information is required to verify the claim in the least intrusive means reasonably available. We applaud this restriction requiring an attempt at "verification by other means". However the proposed rule as phrased does not tie the request for "verification by other means" to the specific concern that gave rise to the need for the examination.

We suggest the following:
An insurer shall not request an examination under oath unless it has **good cause and has been unable to verify the facts by** request**ed****ing** verification by other means ~~and **still requires an examination under oath**~~**.**

Revised Section:

§65-3.4(b)(3)

Revised Text:

Revised Verification of Treatment by Health Service Provider (NYS Form NF-3) requires a Diagnosis Code for each date and each service provided.

Comment:

In addition to Paragraph 5 requiring "Diagnosis and Concurrent Conditions," the Revised Verification of Treatment by Health Service Provider (NYS Form NF-3) requires a specific "Diagnosis Code" for each service. Frequently the particular service provided is related to several diagnosis codes as a single service may be treating more than one condition. It is unclear whether the NF-3 is requiring the provider to identify one, or all of the related codes. It is difficult to understand why this information would need to be provided in addition to the information required by paragraph 5. Requiring the provider to identify and list each related diagnosis code is time consuming, expensive and appear to provide the insurers with little legitimate benefit.

Furthermore, we ask that the Department be mindful that modifying billing software to reflect changes in the Verification of Treatment forms (form that are used exclusively for No-Fault claims) is often a relatively large expense for a small health service provider's office.

Revised Section:

§65-3.5(a)

Revised Text:

Within ~~10 business~~21 calendar days after receipt of the completed application for motor vehicle no-fault benefits (NYS Form N-F-2)~~ or other substantially equivalent written notice~~, the insurer shall forward, to the parties required to complete them, those prescribed ~~verification~~ forms it will require to process ~~prior to payment of~~ the initial claim. An insurer may forward the prescribed forms prior to the receipt of the NF-2.

Comment:

This modification, like many others in this draft, appears designed solely to give the insurer more time, or, in the event that the written notice is provided in a form other than the prescribed NF-2, relieving it from any obligation to provide all parties with the forms it will require to process the claim. It is significant that the revision changes "payment" to "process"--a euphemism suggesting that the insurer might actually be insisting on production of a form merely to further the goal of denying, rather than paying the claim. Once again, we see the insurer benefiting at the expense of the accident victim or health service provider. Those

parties must now wait an additional week to receive those "forms [the insurer] will require to *process* the initial claim." (emphasis added) It should be noted that, although this provision lengthens the time the insurer has to forward the forms, it does not extend any parties' time to submit the completed the forms.

Revised Section:

§65-3.5(e)

Revised Text:

(e) Except with respect to prescribed forms (NF-Forms), as set forth in Appendix 13 of this Title, health service examination and examination under oath requests, an applicant or assignee from whom verification is requested shall provide all such verification under the applicant's or assignee's control and/or possession within 180 calendar days from the forwarding of the initial request for verification or provide written proof providing reasonable justification for the inability to comply with the time limitation.

Comment:

While we are grateful that the drafters of this section made it clear that the time limit is limited to the production of "all such verification under the applicant's or assignee's control and/or possession" we still have grave concerns that this provision will be abused. Even the current rule preventing insurers from denying claims pending the receipt of requested verification is abused by companies that request unnecessary information simply to extend the time to consider the claim. The current proposal gives carriers the added incentive that inaction, or even principled refusal to comply with irrelevant or unreasonable verification requests, could result in forfeiture of the entire claim.

Furthermore, the "exception" provided is really not much of an exception at all as it only applied to situations where the applicant or assignee was unable to comply. The fact that the person may have thought he/she 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.

The inclusion of the 180-day deadline makes it more imperative that the Department provide a dispute resolution process, like expedited arbitration, where

an applicant or assignee can obtain in impartial ruling on abusive requests without fear that the merely requesting such ruling will result in forfeiture of the claim. The Department's current proposal takes a bad situation and makes it worse by providing that the failure to comply within 180 days results in forfeiture of the claim.

We suggest the following modification:

(e) Except with respect to prescribed forms (NF-Forms), as set forth in Appendix 13 of this Title, health service examination and examination under oath requests, an applicant or assignee from whom verification is requested shall provide all such verification under the applicant's or assignee's control and/or possession within 180 calendar days from the forwarding of the initial request for verification or provide written proof providing reasonable justification for the ~~inability~~ **failure** to comply with the time limitation.

Revised Section:

§65-3.5(g)(1)

Revised Text:

(1) When an insurer requests a health service examination, the examination shall be scheduled to be held no earlier than 15 calendar days from the forwarding of the first verification request scheduling the examination.

Comment:

Adding five days for mailing, 10 days remaining notice of medical examinations under the proposed provision is too thin a margin for the insured to properly plan for attendance, especially considering potential employment obligations and obligations toward dependents. We suggest adding five days to the 15-day period to account for mailing.

Revised Section:

§65-3.5(g)(2)

Revised Text:

(2) Every health service examination requested by the insurer shall be held at a time and place reasonably convenient to the applicant. A reasonable place to hold the health service examination shall include the location in the county where the

applicant resides or has an office for the regular transaction of business, or is regularly employed. However, alternate locations may be used upon documented agreement between the applicant and insurer. Every health service examination shall be conducted in a facility properly equipped for the performance of the health service examination. The verification request scheduling the examination shall inform the applicant that the applicant will be reimbursed for any documented loss of earnings and reasonable transportation expenses incurred in complying with the request. The payment for loss of earnings and reasonable transportation expenses is to be made within 30 days after the completion of the health service examination or after appropriate documentation of the loss and expense has been provided to the insurer, whichever is later. The payment shall not constitute basic economic loss.

Comment:

The regulation leaves open what is "appropriate documentation." Insurers will no doubt delay payment of this reimbursement alleging that the documentation is not appropriate or insufficient. Some definition of "appropriate documentation" must be provided. Moreover, to discourage unlawful withholding of such reimbursement, the regulation should provide that the failure to pay lost earning and reasonable transportation expenses within 30 days shall entitle the applicant to the same interest and attorneys fees penalties associated with overdue first party benefits pursuant to Insurance Law 5106.

Revised Section:

§65-3.5(g)(4)

Revised Text:

(4) The insurer shall accommodate at least one request for the adjournment and re-scheduling of the first requested health service examination in each health service area if notice is provided to the insurer on the calendar day prior to the scheduled health service examination. When such adjournment occurs, the re-scheduled date shall be considered the first scheduled date for the purpose of calculating the date a follow-up notice must be forwarded by the insurer should there be a no-show on the rescheduled date. The insurer shall document all adjournments through re-scheduling notices forwarded to the applicant.

Comment:

We are grateful that the Department is considering reducing the time within which an adjournment must be requested to one calendar day. We are concerned that

the penalties associated with such "no-show" could potentially be applied to an applicant who, through no fault of his own, fails to appear or shows up late for a re-scheduled examination. Presently insurers feel that they are under no obligation to consider the reason for the subsequent failure to appear. For example, we have seen benefits denied where applicant's failure to appear for the second examination was due to a recent surgery that rendered the person bedridden, examinations scheduled on public and religious holidays, and those scheduled when the person was out of the country. The examinee frequently does not pick the date for the re-scheduled examination. Some accommodation should be made for unanticipated events that prevent willful compliance. We recognize that the burden to justify a non-appearance at a re-scheduled examination should be placed squarely upon the applicant, or assignee seeking to have the non-compliance excused. Further, as drafted, the proposed regulation authorizes the insurer to repeatedly chose examination times that the insured cannot comply with (for example, in light of medical treatment, existing employment obligations or obligations towards dependants).

As such, we suggest the following language be added to 11 NYCRR 65-3.5(g)(4):

The insurer shall accommodate reasonable requests from the insured regarding the timing and location of the rescheduled examination made at least one business day prior to the rescheduled examination.

In the absence of any prejudice to the insurer, the insurer shall re-schedule a final health service examination where a party immediately notifies the insurer of a circumstance that has prevented or will prevent the applicant from appearing at the final health service examination and promptly provides written proof providing reasonable justification for the inability to appear for the examination.

Revised Section:

§65-3.5(g)(6)

Revised Text:

The insurer need not establish or prove that the failure to attend the examination is a willful or deliberate act on the part of the applicant.

Comment:

This revision is completely unreasonable, contrary to the spirit of the no-fault law and regulations, and carves out no-fault insureds from a right enjoyed by almost all other insureds. An applicant can experience an emergency, not receive notice in a timely fashion, get stuck in traffic, etc. and the insurer would be entitled,

under the strength of this section, to deny not only the applicant's claim, but all his/her assignee's bills. At a minimum, if this regulation stands, the insurer must be required to reschedule even a rescheduled examination if the applicant presents a written explanation providing a reasonable justification for the failure to appear.

Revised Section:

§65-3.5(g) (generally)

Comment:

Currently, insurers usually outsource their examination services to entities that are unknown to the insured. Further, the examination notices from these unknown entities are commonly printed in 9-point type, which is frequently illegible to the elderly and vision impaired. Without attendant protections, the critical examination notices resemble illegible junk mail to most insureds.

Thus, we proposed adding a provision at §65-3.5(g)(7), providing as follows:

All examination notices must be printed entirely in at least 12 point print (in Times New Roman or a similarly sized font) and must be contained in an envelope printed with the name of the insurer and indicating that a timely response is necessary. All examination notices must include contact numbers for rescheduling.

A proof of mailing requirement regarding examination notices avoids swearing matches between the carrier and insured. Considering coverage is completely eliminated by a failure to comply with only two examination notices, directing the insurer to submit notice via certified or registered mail, with a duplicate sent by regular mail, is not a great burden.

Thus, we proposed adding a provision at §65-3.5(g)(8), providing as follows:

All examination notices pursuant to this section, including follow-up notices, must be mailed to both the eligible insured person and his/her attorney, if any. Each required notice must be mailed in duplicate, one by regular mail, one by registered or certified mail, with retention of proof of mailing.

Revised Section:

§65-3.5(h)(1)

Revised Text:

An insurer shall not require an examination under oath of an applicant or assignee to establish proof of claim, except based upon the application of objective written standards. Objective written standards shall be available for review by the superintendent.

Comment:

This revision represents a relaxation of an already lax rule. Under this proposal the use of an examination under oath must be based upon "the application of objective written standards." While this proposal would require the standards to be written, there is no requirement that there be a "specific objective justification" in any particular case. Further, the Department has provided no guidance as to how the insurer is to formulate such standards. A written policy to conduct an examination under oath of every applicant or assignee would comply with this provision as proposed. We urge the Department to provide guidance on the use of Examination Under Oath. We further urge the Department to clearly establish that Examinations Under Oath should only be utilized where the insurer has been unable to verify the claim through less burdensome means and has good cause to believe that such examination is necessary to verify the claim. Finally, we suggest that each insurer should file the standards with the Department rather than merely allowing them to be subject to inspection.

Revised Section:

§65-3.5(h)(3)

Revised Text:

Every examination under oath requested by the insurer shall be held at time and place reasonably convenient to the applicant or assignee being examined. A reasonable place to hold the examination under oath shall include the location in the county where the party being examined resides, has an office for the regular transaction of business, or is regularly employed, or in the county where such party's legal representative's office is located. However, an alternate place may be used upon documented agreement between the applicant or assignee being examined and the insurer. The verification request scheduling the examination shall inform the applicant or assignee being examined that the insurer will arrange for a translator if necessary upon written notice. The verification request scheduling the examination shall inform the applicant or assignee being examined that there will be reimbursement for any documented loss of earnings and reasonable transportation expenses incurred in complying with the request. The payment for loss of earnings

and reasonable transportation expenses is to be made within 30 days after the completion of the examination under oath or after appropriate documentation of the loss and expense has been provided to the insurer, whichever is later. The payment shall not constitute basic economic loss.

Comment:

It is appropriate that the notice scheduling an Examination Under Oath inform the applicant or assignee that upon request the insurer will arrange for a translator. Clearly this is preferable to allowing insurers to demand that applicants bring their own interpreter to the examination. However, we question what actual benefit from a rule that allows such notice to be delivered in English, to a person that the insurer knows cannot read English.

The regulation also does not define what is "appropriate documentation" of lost earnings and reasonable transportation expenses. Insurers will no doubt delay payment of this reimbursement alleging that the documentation is not appropriate or insufficient. Some definition of "appropriate documentation" must be provided. Moreover, to discourage unlawful withholding of such reimbursement, the regulation should provide that the failure to pay lost earning and reasonable transportation expenses within 30 days shall entitle the applicant to the same interest and attorneys fees penalties associated with overdue first party benefits pursuant to Insurance Law 5106.

Finally, we renew our concern that the proposal permits insurers to send the notices only to the party to be examined. There should be a specific rule that where an insurer knows a person is represented by an attorney, that notices must be sent to both the person, and that person's attorney. This is especially important in light of the fact that the failure to appear may result in the complete forfeiture of benefits.

As such, we suggest the following:

Every examination under oath requested by the insurer shall be held at time and place reasonably convenient to the applicant or assignee being examined. A reasonable place to hold the examination under oath shall include the location in the county where the party being examined resides, has an office for the regular transaction of business, or is regularly employed, or in the county where such party's legal representative's office is located. However, an alternate place may be used upon documented agreement between the applicant or assignee being examined and the insurer. **The verification request scheduling the examination shall be sent to the applicant or assignee being examined at their most recent address, and if the insurer has received written notice that such party is represented by counsel, to their legal representative.** The verification request scheduling the examination shall inform the applicant or assignee being examined that the insurer

will arrange for a translator if necessary upon written notice. **Where the insurer has knowledge that the applicant or assignee does not speak English, such notice shall be in a language the person does understand.** The verification request scheduling the examination shall inform the applicant or assignee being examined that there will be reimbursement for any documented loss of earnings and reasonable transportation expenses incurred in complying with the request. The payment for loss of earnings and reasonable transportation expenses is to be made within 30 days after the completion of the examination under oath or after appropriate documentation of the loss and expense has been provided to the insurer, whichever is later. The payment shall not constitute basic economic loss.

Revised Section:

§65-3.5(h)(4)

Revised Text:

A verification request scheduling an examination under oath must set forth the general subject matter (including licensing, staged accident, treatment not rendered) to be addressed at the examination under oath. The insurer's questions at the examination may include inquiry into areas reasonably related to the identified general subject matter, and all questions must be limited to what is necessary to establish proof of claim. The request shall advise the applicant or assignee being examined that the applicant or assignee may have legal representation at the examination under oath at the applicant or assignee's own expense. 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; however, the objection shall not excuse the failure of the applicant or assignee being examined from not responding to the questions relevant to the establishment of proof of claim.

Comment:

We find it more appropriate that the current proposal does not include the earlier proposed language permitting questioning to areas beyond those set forth in the general subject matter of the request.

However, we are concerned that the language permitting objections to "scope or relevance" might be interpreted as limiting objection solely to those grounds. There should be no such limitation. There is little justification for permitting an objection as to scope or relevance, but prohibiting 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.

As such, we propose the following language be used:

> 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; however, the objection **alone** shall not excuse the failure of the applicant or assignee being examined from not responding to the questions relevant to the establishment of proof of claim.

Revised Section:

§65-3.5(h)(5)

Revised Text:

The insurer shall accommodate at least one request for the adjournment and re-scheduling of the first scheduled examination under oath if notice is provided to the insurer on the calendar day prior to the scheduled examination under oath. When such adjournment occurs, the re-scheduled date shall be considered the first scheduled date for the purpose of calculating the date a follow-up notice must be forwarded by the insurer should there be a no-show on the re-scheduled date. Every adjournment must be documented through re-scheduling notices provided to the person to be examined.

Comment:

We are concerned that the penalties associated with the failure to appear for a re-scheduled examination under oath could potentially be applied to an applicant or assignee who, through no fault of his own, fails to appear or shows up late for a re-scheduled examination. As with medical examinations, insurers feel that they are under no obligation to consider the reason for the subsequent failure to appear. The examinee may not have had a say in the chosen re-scheduled date and some

accommodation should be made for some an unanticipated event that prevented compliance.

Furthermore, in the interest of obtaining compliance, where the insurer has received written notice that a party is represented by counsel, the insurers should be required to notify the party and their counsel of the re-scheduled examination.

We ask that you consider adding the following:

The insurer shall accommodate at least one request for the adjournment and re-scheduling of the first scheduled examination under oath if notice is provided to the insurer on the calendar day prior to the scheduled examination under oath. When such adjournment occurs, the re-scheduled date shall be considered the first scheduled date for the purpose of calculating the date a follow-up notice must be forwarded by the insurer should there be a no-show on the re-scheduled date. **In the absence of any prejudice to the insurer, the insurer shall re-schedule a second re-scheduled examination under oath where a party immediately notifies the insurer of a circumstance that has prevented or will prevent the applicant or assignee from appearing at the examination under oath and promptly provides written proof providing reasonable justification for the inability to appear for the examination.** Every adjournment must be documented through re-scheduling notices provided to the person to be examined **and if the insurer has received written notice that such person is represented by counsel, to their legal representative**.

Revised Section:

§65-3.5(h)(8)

Revised Text:

With respect to an examination under oath as to whether the assignee has met the applicable New York State or local licensing requirement necessary to perform the service in this State, or meet any applicable licensing requirement necessary to perform the service in any other state where the service is performed, the insurer shall only request an examination under oath when there is good cause to do so. The request pends the payment or denial of all pending and subsequent claims for benefits of that assignee for all applicants from the insurer, based upon services billed for by the assignee, until the time that the examination under oath process is completed as provided in paragraph (9) of this subdivision. The insurer shall provide a notice of pending claim to the assignee for each claim submitted to the insurer which cannot be paid or denied because an examination under oath is required of the assignee to establish proof of claim. The notice shall advise that an examination under oath has been requested of the assignee and shall be sent with

a copy of the request for the examination under oath within 21 calendar days after receipt of each claim.

Comment:

It is most appropriate that the latest proposal explicitly states an examination under oath may only be requested when there is good cause to do so. We are hopeful that this language will go far towards discouraging most insurers from abusing this device. However, as proposed these 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. Assignees need access to some forum (such as expedited arbitration) where a neutral party can review the insurers assertion and render a prompt determination that the use of such the licensure review is appropriate without fear of forfeiture of all pending claims.

ADD SUGGESTED LANGUAGE HERE

Revised Section:

§65-3.5(h)(9)

Revised Text:

Verification of a request for an examination under oath is deemed received by the insurer:

i. On the date of the second scheduled examination under oath, scheduled pursuant to subdivision (d) of section 65-3.6 of this Subpart, if the party to be examined fails to appear on that date.
ii. On the date of receipt of the signed examination under oath transcript by the insurer, but in any event, no later than 60 calendar days after the examination under oath was performed.

Comment:

Subsection ii seems to imply that the request for an examination under oath is deemed to be received, not on the date of the examination, but upon the date the transcript is returned. The significance of the language "but in any event, no later than later than 60 calendar days after the examination under oath was performed" is unclear. Since §65-3.5(h)(10) provides that the transcript after 60 days may be used as "fully as though signed," it is essentially self-executing. If the intention is to consider the response to a request for the examination to be received 60 days

after the examination in the absence of a return of the transcript, we suggest the following language:

ii. On the **earlier of: the** date of receipt of the signed examination under oath transcript by the insurer**; or ~~but in any event, no later than~~** 60 calendar days after the **transcript of the** examination under oath was **submitted to the applicant or assignee ~~performed~~**.

Furthermore, since after 60 days the transcript may be used as "fully as though signed," following change should be made to the Proof of Claim section of the Mandatory Endorsement:

Upon request by the Company, the ~~eligible injured person~~applicant or that person's assignee or representative shall:

(a) execute a written proof of claim under oath;

(b) as may reasonably be required submit to examinations under oath by any person named by the Company **~~and subscribe the same~~**;

Revised Section:

§65-3.5(h)(11)

Revised Text:

With respect to examinations under oath of an assignee, an insurer shall be limited to one examination of the assignee to address that assignee's ability to meet any applicable New York State or local licensing requirement necessary to perform the service in this State, or meet any applicable licensing requirement necessary to perform the service in any other state where the service is performed (inclusive of corporate structure, ownership, or corporate practice of medicine issues), unless the insurer has a reasonable belief that new facts emerged concerning the assignee since the previous examination under oath.

Comment:

The Department's 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 examinations under oath 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 that newly discovered 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.**

Revised Section:

§65-3.5(r)

Revised Text:

An Insurer requested health service examination or peer review report shall be in writing and signed by the health service professional that conducted the examination or did the review. The report shall be based on the examination of an applicant or a review of the applicant's health and other records. Once a report has been signed by the health service professional that conducted the examination or did the review, the report shall not be modified by anyone other than the health service professional who signed the report. Neither an insurer nor any person acting at the direction of or on behalf of an insurer shall change or seek to change the conclusions reached in a health service examination or peer review report rendered by a health service professional. However, an insurer may request an addendum to a report.

Comment:

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 heathcare professional whose name appears on the report.

We request the following language:

An Insurer requested health service examination or peer review report shall be in writing and signed by the health service professional that conducted the examination

or did the review. **Such reports ~~The report~~** shall be based on the examination of an applicant or a review of the applicant's health and other records. **The reports ~~Once a report has been signed by the health service professional that conducted the examination or did the review, the report~~** shall not be modified by anyone other than the health service professional who signed the report. Neither an insurer nor any person acting at the direction of or on behalf of an insurer shall change or seek to change the conclusions reached in a health service examination or peer review report rendered by a health service professional. However, an insurer may request an addendum to a report.

Revised Section:

§65-3.6(c) and (d)

Revised Text:

(c) When the verification requested from an applicant is a health service examination that resulted in no-show by the applicant (not including an agreed upon adjournment), the insurer shall, within ten calendar days of the no-show, forward a follow-up notice scheduling another health service examination. The second and final scheduled health service examination shall be held no earlier than 15 calendar days from the date of the follow-up notice scheduling the examination, unless the second examination is adjourned upon mutual agreement. The insurer shall provide written notice of adjournment to the party to be examined.

(d) When the verification requested is an examination under oath that resulted in a no-show by the party being examined (not including an agreed upon adjournment), the insurer shall, within ten calendar days of the no-show, provide a follow-up notice scheduling another examination under oath. The second and final scheduled examination under oath shall be held within 15 to 45 calendar days from the date of the follow-up notice scheduling the examination, unless the second examination is adjourned upon mutual agreement. The insurer shall provide written notice of adjournment to the party to be examined.

Comment:

As noted earlier, the penalties associated with the failure to appear for a re-scheduled examination under oath could potentially be applied to an applicant or assignee who, through no fault of his own, fails to appear or shows up late for a

re-scheduled health service examination, or a second re-scheduled examination under oath. Frequently, the examinee may not have had a say in the chosen re-scheduled date. There should be some fair mechanism for balancing the insurer's need to verify the claim against the understanding that events beyond our control sometimes intervene. The fact that there may have been an earlier adjournment, or re-scheduling does not speak to issues that may arise on the date of the final examination. Some accommodation should be made for an unanticipated event that prevented compliance.

Also, as repeatedly noted in the interest of obtaining compliance, where the insurer has received written notice that a party is represented by counsel, the insurers should be required to notify the party and their counsel of the re-scheduled examination.

We ask that the Department consider adding the following language to §65-3.6(c)

In the absence of any prejudice to the insurer, the insurer shall re-schedule a re-scheduled health service examination where a party immediately notifies the insurer of a circumstance that has prevented or will prevent the applicant or assignee from appearing at the examination and promptly provides written proof providing reasonable justification for the inability to appear for the examination.

We ask the Department consider adding the following language to §65-3.6(d)

In the absence of any prejudice to the insurer, the insurer shall re-schedule a second re-scheduled examination under oath where a party immediately notifies the insurer of a circumstance that has prevented or will prevent the applicant or assignee from appearing at the examination under oath and promptly provides written proof providing reasonable justification for the inability to appear for the examination.

We ask the Department consider adding the following language to §65-3.6(c) and (d)

If the insurer has received written notice that such person is represented by counsel, re-scheduling notices shall be sent to the person to be examined and their legal representative.

Revised Section:

§65-3.8(b)(3)

Revised Text:

~~Except as provided in subdivision (e) of this section, a~~An insurer shall not issue a denial of claim form (NYS Form N-F ~~-~~10) prior to its receipt of verification of all of the relevant information requested pursuant to sections 65-3.5 and 65-3.6 of this ~~s~~Subpart. (~~e.g., medical reports, wage verification, etc.)~~ However, an insurer may issue a denial, provided that the outstanding verification was requested from either the applicant or assignee, with the exception of prescribed forms (NF-Forms), as set forth in Appendix 13 of this Title, health service examination and examination under oath requests, if more than 180 days from the date the initial request was provided have passed.

Comment:

We are concerned that this section as written could be utilized to authorize the denial of a party's claim based upon the failure of another applicant or assignee to provide verification in a timely manner. Such denials should be strongly discouraged, or permitted only after the insurer has made exhaustive attempts to obtain information that is truly necessary for any determination.

If the Department intends to permit such denials, we strongly recommend that is consider the potentially unfair consequences flowing from denying one assignee's claim because another assignee was unwilling to comply with a request. If on the other hand, the intention is to not permit such denial, we suggest the department change the language as indicted herein:

> ~~Except as provided in subdivision (e) of this section, a~~An insurer shall not issue a denial of claim form (NYS Form N-F ~~-~~10) prior to its receipt of verification of all of the relevant information requested pursuant to sections 65-3.5 and 65-3.6 of this ~~s~~Subpart. (~~e.g., medical reports, wage verification, etc.)~~ However, an insurer may issue a denial **to a particular applicant or assignee**, provided that the outstanding verification was requested from **that particular**~~either the~~ applicant or assignee, with the exception of prescribed forms (NF-Forms), as set forth in Appendix 13 of this Title, health service examination and examination under oath requests, if more than 180 days from the date the initial request was provided have passed.

Revised Section:

§65-3.8(g)

Revised Text:

(g) Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant or assignee to an insurer and no payment shall be due for such claimed services under any circumstances:

(1) when the claimed services were not provided to the applicant;

(2) for those claimed service fees that exceed the charges permissible under the schedules prepared and established pursuant to section 5108 (a) and (b) of the New York Insurance Law for services rendered by New York health service providers.

Comment:

While we applaud the Department's goal to prevent reimbursement in excess of the established schedules or for services that were not provided, this revised section is cumbersome and strangely worded. It is difficult to imagine its practical effect on court and arbitration proceedings. Typically, the applicant or assignee has the burden of establishing that Proof of Claim was submitted to the insurer, and thereafter the insurer may establish its defenses. The section essentially "deems" such proof to have been "not supplied" in two circumstances—two circumstances that may not even exist in a specific case.

There is a more effective and clearer way to accomplish the Department's aim, without the confusing "shall not be deemed" language and without running afoul of what the Appellate Courts have determined to be a claimant's *prima facie* case. Accordingly, we suggest the following language be used:

The failure to issue a Denial in accordance with section 65-3.8 shall not preclude the insurer's from raising the following defenses:

1. **That the services billed for in a claim were not provided to the applicant;**

2. **That certain portions of the charges for services in a claim exceed the charges permissible under the schedules prepared and established pursuant to section 5108 (a) and (b) of the New York Insurance Law.**"

Revised Section:

§65-3.11(e) and (f)

Revised Text:

(~~d~~e) If an assignment has been furnished, an insurer, the assignor or ~~legal representative of the assignor~~ assignee shall not unilaterally revoke the assignment~~.~~, unless such revocation by the assignee is authorized pursuant to the prescribed language of the assignment. An assignment may only be terminated upon a written agreement between the assignor and the assignee. The revocation or termination of the assignment shall not be effective for services rendered prior to the date of revocation or termination~~after the services for which the assignment was originally executed were rendered. If the assignment is revoked for services not yet rendered, the assignor or legal representative shall provide written notification to the insurer that the assignee has been notified of the revocation.~~

(f) After execution of the written revocation or termination agreement, a copy of the agreement shall be submitted to the insurer.

Comment:

The coma after furnished in the lead sentence of this section implies that the insurer, the assignor or the assignee may revoke an assignment if such is permitted by the terms of the assignment. This is problematic on a number of levels. First, an insurer is not a party to an assignment, and as such, has no legal authority to modify what is essentially an agreement between the patient/employee and the provider/employer.

The second problem stems from the terms of the prescribed Assignment of Benefits form (NF-AOB). In order to protect accident victims from providers that seek payment from their patients when they are unable to collect payment from the insurer, the NF-AOB contains a provision prohibiting the provider from demanding payment from the patient. However, in order to ameliorate against the harsh effects of such prohibition, the NF-AOB permits the provider to "revoke" the agreement and presumably pursue payment from the patient "when benefits are not payable based upon the assignor's lack of coverage, and/or violation of a policy condition due to the actions or conduct of the assignor."

We are concerned that the proposed language requiring a revocation of the assignment to be in a writing signed by both the assignor and assignee could be interpreted as barring a provider who is unable to seek payment from the insurer "when benefits are not payable based upon the assignor's lack of coverage, and/or

violation of a policy condition due to the actions or conduct of the assignor" without a further agreement signed by the patient.

A provider that has rendered services for which benefits are unavailable solely due to the assignor's failure to have insurance coverage, or the violation by the patient of a policy condition, the provider should not have to get written permission from the patient to demand payment.

As such, we request the following language be added to 65-3.11(e).

> **Nothing in this section shall require a health service provider to obtain a written agreement from the assignor before pursing payment from the assignor where benefits are not payable based upon the assignor's lack of coverage, and/or violation of a policy condition due to the actions or conduct of the assignor.**

Revised Section:

§65-4.3

Comment:

Throughout this commentary we have referenced the need for applicants and assignees, faced with deadlines to comply with verification requests and examinations under oath, to have access to a forum where they can seek a ruling regarding demands for verification and examinations under oath without fear that the mere act of seeking a ruling will itself result in the expiration of the time for compliance.

Insurance Law 5106(b) requires:

> Every insurer shall provide a claimant with the option of submitting ***any dispute*** involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) hereof to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Emphasis Added.

Unfortunately, the time frames established in the proposed draft regulations are insufficient to permit an applicant or assignee to obtain a ruling regarding a

disputed verification request or request for an examination under oath before the claim is forfeit.

We believe that such the following changes are needed to further the mandate of Insurance Law 5106(b):

Suggested Revised Text:

(b) Special Expedited Arbitration.

(1) Special Expedited Arbitration shall be available for disputes involving:

(i) The failure to submit notice of claim within 30 calendar days after the accident and where it has been determined by the insurer that reasonable justification for late notice has not been established; and

(ii) The proper application of benefits priority as set forth in subdivisions (b) and (c) of Section 65- 3.12 of this Part and of paragraphs (2), (3) and (4) of ~~S~~section 65-3.13(a) of this Part.

(iii) The propriety of any request for verification or examination under oath

(2)

(i) An applicant may request special expedited arbitration for resolution of the dispute involving late notice within 30 calendar days after mailing of the denial of claim by the insurer stating that reasonable justification for late notice has not been established.

(ii)(a) In regard to disputes related to subdivisions (b) and (c) of section 65-3.12 or paragraphs (2), (3) and (4) of section 65-3.13(a) of this Part, an applicant may request special expedited arbitration to designate an insurer that is responsible for processing first-party benefits and additional first party benefits, after each insurer has issued a Denial of Claim form (NF-10) stating that the insurer is not the insurer eligible to process the first-party benefits claimed.

(ii)(b) Special expedited arbitration required by clause (a) of this subparagraph shall only designate an insurer to commence processing the claim based upon the first insurer notified that is otherwise liable for the payment of first party benefits. The insurer designated by the arbitration shall retain all rights of investigation afforded under statute and regulation, and the ultimate liability for payment of benefits shall

(iii) A properly filed request for arbitration or expedited arbitration pursuant to (b)(1)(iii) of this section shall toll the time for the applicant or assignee to comply with the request

verification or examination under oath until 30 calendar days after the transmittal of the arbitrator's decision.

Conclusion

We again reiterate our appreciation and gratitude for being afforded the opportunity to present the viewpoint of claimants seeking payment for health services. We are gravely concerned that some of the changes proposed, particularly the provisions requiring each bill to be submitted with documentary proof of necessity, the threat of forfeiture of the claim unless all insurer demands are promptly met, the failure to provide a forum for resolution over verification request disputes including disputes regarding examinations under oath, will discourage legitimate providers from treating automobile accident victims. NYFAIR has suggested a number of proposals, however, we recognize different approaches may be available to address the concerns of all parties, and would welcome the opportunity to further assist the Department in designing alternate approaches to these problems.

Very truly yours,

Stuart Israel

President

New Yorker for Fair Automobile Insurance Reform