GREATER NEW YORK HOSPITAL ASSOCIATION
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June
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Howard Zucker, MD, JD
Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Linda Lacewell
Superintendent
New York State Department of Financial Services
One State Street
New York, NY 10004-1511

Dear Commissioner Zucker and Superintendent Lacewell:

UnitedHealthcare (UHC) has announced a new policy (attached) regarding its review of hospital claims for emergency department (ED) services. Under the policy, UHC apparently will no longer use the prudent layperson standard in its initial determination on whether an ED service was medically necessary. GNYHA believes this policy violates Article 49 of both insurance and public health laws.

Under UHC's policy, it will evaluate ED claims based on the presenting problem, the intensity of the diagnostic services performed, and other complicating factors. If UHC determines the ED visit was not medically necessary, it will deny coverage and then provide the hospital with the opportunity to submit an attestation indicating that the service was consistent with the prudent layperson standard. Both the Department of Health and the Department of Financial Services have issued opinions (attached) based on Article 49 that health plans must use the prudent layperson definition in their adjudication of claims to determine coverage for ED services. Health plans therefore cannot issue a denial of coverage and then initiate a review based on the prudent layperson standard if the hospital in effect appeals. The UHC policy is applicable to commercial coverage and is being rolled out over the coming months, with implementation in New York possibly scheduled for January.

GNYHA strongly believes that this policy is simply another attempt by UHC to deny or delay payment to hospitals for medically necessary services, and we respectfully request that you notify UHC that implementation is prohibited in New York.

Thank you for your assistance in this matter.

Sincerely,

Kenneth E. Raske
President

Attachment

How we're assessing emergency department facility commercial claims

Effective July 1, 2021, we will enhance our capabilities to assess emergency department (ED) facility commercial claims to determine if the ED event was emergent or non-emergent, according to existing plan provisions, in most states.

ED claims will be evaluated based on many factors, including:

- The patient's presenting problem
- The intensity of diagnostic services performed
- Other patient complicating factors and external causes

Claims determined to be non-emergent will be subject to no coverage or limited coverage in accordance with the member's Certificate of Coverage. This enhanced capability will apply to commercial fully insured ED facility claims in many states for dates of service on July 1, 2021, or later. Subject to regulatory approval we will continue to expand this capability to additional states and segments.

Non-emergent

If an ED event is determined to be non-emergent, you'll have the opportunity to complete an attestation if the event met the definition of an emergency consistent with the prudent layperson standard.

Attestation

A notice of the opportunity to submit an attestation will be sent electronically to the facility when an ED event is determined to be non-emergent. Instructions about accessing the attestation through **UHCprovider.com** will be included. We may also follow up with a mailed letter about the attestation.

If the attestation is submitted within the required time frame, the claim will typically be processed according to the plan's emergency benefits.

UnitedHealthcare reserves the right to order medical records for claims review, even if an attestation has been submitted.

Questions? Contact Provider Services at **877-842-3210** or your Network Representative.

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Network Bulletin Home Page

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

November 30, 2001

The purpose of this letter is to clarify the Department's policy regarding the implementation of the mandated emergency benefit and prudent layperson standard established in Article 49 of the Public Health Law (PHL). Issues have arisen regarding claims adjudication utilizing the prudent layperson standard and appeal rights for members and providers. It is DOH's position that utilization review, internal appeals and external appeals of the medical necessity of health care services to treat an emergency condition in the hospital facilities are determinations subject to PHL Article 49, not Article 44. Therefore, utilization review (if adverse to the enrollee), internal appeals and external appeals concerning such issues must be conducted by clinical peer reviewers in accordance with Article 49, and not by others as might be appropriate for grievances under Article 44. Although the standard for review of medical necessity in such emergency cases incorporates the "prudent layperson" standard of PHL 4900(3), the persons who apply those standards must be clinical peer reviewers, not other health care professionals who are not clinical peer reviewers, and not laypersons. A more detailed explanation of our position follows.

As indicated previously by the Department, the determination on whether the prudent layperson standard is met must be made on a case by case basis. Claims for emergency room services cannot be denied based solely upon the review of final diagnostic and procedure codes, such as ICD 9 or CPT codes, associated with the emergency room visit. MCOs may choose to approve claims based upon certain codes. In addition, MCOs may also pend claims for further evaluation based upon codes. However, denials may not be issued under the prudent layperson standard until the MCO has evaluated the presenting symptoms associated with the visit, and when evaluating the presenting symptoms, the MCO must consider whether a prudent layperson would have decided to seek emergency services under the same circumstances.

Some MCOs have taken the position that reviews of emergency services involve only the issue of whether the enrollee was prudent in seeking emergency services, do not involve a

medical necessity determination, and may be handled as a grievance under section 4408-a of the PHL. However, the placement of the definition of an emergency condition in section 4900(3) of Title I, Certification of Agents and the Utilization Review Process, of Article 49 of the Public Health Law (PHL) by the legislature strongly supports the Department's position that reviews of emergency services must include a review of the medical necessity of such services. A determination about whether emergency room services are medically necessary is a function of utilization review. If the legislature intended that a plan review the necessity of an emergent condition under the member grievance and appeal process, the definition would have been included under section 4401 of the PHL.

Section 4902(h) of the PHL precludes MCOs from requiring prior authorization for emergency services. However, it does not preclude a plan from performing a retrospective review of such services. The procedures for such reviews of all services must comply with sections 4902 and 4903 of the PHL. There are no separate express standards or procedures for addressing the retrospective review of emergency room services, nor criteria indicating that a prudent layperson should be conducting such review. Section 4903 allows for trained administrative personnel to perform only intake screening, data collection and non-clinical review functions. As you are aware, adverse determinations must be rendered by a clinical peer reviewer. A prudent lay person is not a *clinical* peer and therefore cannot render an adverse determination. The statute does allow for a clinician to evaluate whether the presenting symptoms could be reasonably construed by an individual as another, more emergent, condition. Therefore, we conclude that the review of emergency room conditions falls under utilization review; and that a prudent layperson cannot be involved in an adverse determination regarding such services.

The grievance and appeal process described in Public Health Law Section 4408-a is reserved for situations involving member claims payment and other member disputes not involving utilization review. Often MCOs establish procedures for providers to appeal administrative determinations made by the MCO, including claims payment disputes. With respect to providers, if payment requirements for the provision of emergency services are negotiated and reflected in the contract between the hospital and MCO, those arrangements may be acceptable to the Department as long as the member is held harmless from payment. In such cases where the MCO negotiates administrative requirements such as provider notification and timeframes for claims submission, and the denial of the claim is based on failure to adhere to such contractual requirements, Article 49 would not be applicable. Instead, appeals of such denials would be subject to the MCO's provider appeal process, if one has been established, or to arbitration or judicial review. However, the contract terms and conditions may not result in the member being held responsible for the costs of the services if the denial is a result of the provider's breach of such contractual provisions. Any resulting payment dispute would be handled between the MCO and provider. Non-participating providers cannot be required to adhere to such administrative requirements since they do not have agreements with the MCO.

For Medicaid enrollees, MCOs pay a triage fee for services provided in the emergency room that do not meet the prudent layperson standard unless an alternate payment arrangement has been negotiated. The triage fee was not established by the commissioner to be a default payment for all emergency services. The triage fee amount, like all other provider payments, is subject to negotiation between parties. However, in the event there is no negotiated rate, a default rate of forty (40) dollars has been set in the Medicaid Managed Care program contract between the counties and the MCOs.

If MCOs are paying the triage fee, the assumption is that a determination has been made that the prudent layperson standard has not been met. The payment of the triage fee must also be made on a case by case basis, and cannot be based solely upon the final diagnostic codes. As indicated in the State Medicaid letter from the Center for Medicaid and Medicare (CMS), whenever an MCO denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard is met must be based on all pertinent documentation. Therefore, for Medicaid if MCOs are pending cases based upon diagnostic codes, they must evaluate each specific case in question to determine if the prudent layperson standard has been met before paying the triage fee. MCOs are precluded from automatically paying the triage fee, without an evaluation under the prudent layperson standard, and then requiring resubmission of the claim as part of an appeals process, unless agreed to as a payment arrangement as part of the contract between the provider and the plan. Where agreed to in contract, payment of the triage fee may be considered a partial payment while an evaluation under the prudent layperson standard is conducted. In the absence of such a contractual agreement, all assessments regarding the prudent layperson standard must be made prior to payment of the triage fee. If the MCO, following a complete evaluation of the presenting symptoms concludes that, in applying the prudent layperson standard, there was no emergency medical condition and only the triage fee may be paid, appeal rights attendant to an adverse determination must be given to the member and provider pursuant to Article 49 of PHL. In all cases, the member must be held harmless from payment.

We trust that this letter clarifies the Department's policy regarding the mandated emergency benefit and prudent layperson standard. Please do not hesitate to contact me or Vallencia Lloyd should you have any questions concerning this matter.

Sincerely,

Kathleen Shure

Kathleen Shure
Director
Office of Managed Care

Department of Financial Services

Industry Guidance

TO:	ALL INSURERS LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE IN NEW YORK STATE, INCLUDING ARTICLE 43 CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS
RE:	CLARIFICATION OF EMERGENCY CARE COVERAGE

STATUTORY REFERENCES: Insurance Law Sections 3216, 3221, 4303 and Article 49; Public Health Law Article 49

Insurance Law Sections 3216(i)(9), 3221(k)(4) and 4303(a)(2) mandate coverage of services to treat an emergency condition in hospital facilities and define an "emergency condition" as follows:

"Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

Issues have recently arisen concerning claims adjudication using the prudent person standard, appeal rights and improper conditions placed on coverage. The purpose of this Circular Letter is to set forth the Department's position with regard to the administration of this mandated benefit for emergency services.

CLAIMS ADJUDICATION

It has come to our attention that insurers, Article 43 corporations and HMOs may be denying coverage for emergency services based upon the final diagnosis code, such as ICD 9 or CPT 4 codes, assigned to the emergency room visits. Although the diagnosis code may be used to approve coverage of emergency services, its use as the basis for denial of coverage is improper. The standard by which to evaluate whether a denial of coverage is supportable is the "prudent layperson" standard required by the Insurance Law. Whenever a claim is denied, the determination of whether the prudent layperson standard has been met (1) must be based on all pertinent documentation, (2) must be focused on the presenting symptoms and not on the final diagnosis and (3) must take into account that the decision to seek emergency services was made by a prudent layperson rather than a medical professional.

APPEAL RIGHTS

Article 49 of the Insurance Law, in Sections 4900(c), 4901(a)(5), 4902(a)(8) and 4905(m), recognizes that determination of coverage of emergency services is a function of the utilization review process. Section 4901(a)(5) requires that the utilization review report filed with the Department contain a description of the emergency care policy. Section 4902(a)(8) requires that a utilization review agent adhere to program standards that include a requirement that emergency services rendered to an insured shall not be subject to prior authorization. That Section further requires that reimbursement for such services not be denied on retrospective review; provided however, that such services are medically necessary to stabilize or treat an emergency condition. Finally, Section 4905 prohibits a prior notice requirement on receipt of emergency care. Identical provisions in the Public Health Law make these requirements applicable to HMOs.

Because the statutory benefit for emergency services employs the prudent layperson standard discussed above, any assessment of medical necessity for emergency services pursuant to Article 49 must take this standard into account. Emergency services rendered by hospital facilities would be medically necessary if they were provided in treatment of an emergency condition. When, pursuant to Section 4902(a)(8), retrospective review results in a finding that emergency services were not medically necessary, it must be because under a prudent layperson standard the services were not rendered to treat an emergency condition.

In the event of a denial, the insured, his or her designee and the provider shall be afforded appeal rights consistent with Article 49. However, at each level of appeal, the prudent layperson standard must be applied in assessing whether the emergency services were medically necessary.

NOTIFICATION REQUIREMENTS

Many insurance policies and subscriber contracts contain provisions that would require the insured or someone on the insured□s behalf to notify the insurer within a contractually established timeframe that emergency services were received. These post-emergency notification procedures do not appear in statute and were permitted by the Department administratively based on arguments by health plans that notice was necessary so that the health plans could coordinate follow-up care and assure access to quality and appropriate services. Since the sweeping changes made to the law since 1997 to address how managed care plans provide health care services, we have had reason to reassess allowing post-emergency notification requirements.

In some cases, health plans use the notice requirements to deny or reduce benefits of an otherwise appropriate access of emergency care. Since the Insurance Law mandates coverage of emergency services received in hospital facilities and it does not condition such coverage on the insured giving notice to the health plan of the receipt of such care (apart from submitting a claim for services), the failure by the insured to give notice should not be considered in making a decision to cover the services in question. To deny or reduce benefits on this basis would be inconsistent with the Insurance Law.

We appreciate, however, the importance of a health plan□s ability to manage and coordinate care under a managed care plan. We are willing to continue to approve provisions that discuss notification by the insured so long as such notification is suggested rather then required and no reduction or denial of benefits for receipt of otherwise covered emergency services results from a failure to notify. Health plans are directed to review both their contract provisions and their policy and procedures for processing claims for emergency care and make required changes consistent with this Circular Letter.

Any questions on this Circular Letter may be directed to:

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Health Bureau

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Or by e-mail to dkozemko@ins.state.ny.us,

Thomas C. Zyra
Co-Chief, Health Bureau

Very truly yours,

Charles S. Henricks
Chief Examiner and Co-Chief,
Health Bureau