New No-Fault Regulations to Take Effect April 1 in New York State

The Department of Financial Services, announces the proposed new amendments to take effect April 1. It is asserted that the amendments are necessary to: 1.) prevent health care providers from being paid for services they do not actually provide; and 2.) Alleviate certain issues that may be used to prevent a decision on a claim or keep an otherwise faulty claim open.

The amendments (1) do away with certain statutory requirements, which in effect require insurers to pay for treatments that were never actually provided or pay more than the established fee schedule for a given service; (2) prevent health care providers from ignoring requests for verification concerning the medical necessity of treatment by setting a 120-day deadline to provide such requested information; and (3) close the apparent loophole that requires insurers to pay for non-rendered medical services simply because of technical errors made by those insurers during the claims process.

Specifically, Subdivisions (g) through (j) of section 65-3.8 are re-lettered subdivisions (i) through (l) and new subdivisions (g) and (h) are added to read as follows:

(g) (1) Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances:

(i) When the claimed medical services were not provided to an injured party; or

(ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

(h) With respect to a denial of claim (NYS Form N-F 10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim.

This amendment is applicable to medical services rendered on or after April 1, 2013.

Time Limit for Responding

Normally, an insurance company is required, within 30 days of receiving a no-fault claim from a health care provider, to pay or deny the claim, or, within 15 days, send a request for additional information to verify the claim. Once the insurer receives verification, it has an additional 30 days to pay or deny the claim. There is no statutory deadline for a provider to respond to a verification request and an insurer may not deny or close a claim if it does not receive the verification. As a result, some claims remain open, or tolled, indefinitely. This can become very costly for insurers as under the law, insurers must pay a very high interest rate on delayed payments.

The new Amendment addresses this issue by creating a deadline to respond to the verification request. The provider must now provide a response within 120 days of an insurer's verification request, or provide reasonable justification why it cannot do so. Should the applicant fail to do one or the other, the amendment permits an insurer to deny the claim, thus speeding up the claims process and reducing the number of claims that remain tolled indefinitely.

Specifically, new subdivisions (o) and (p) are added to section 65-3.5 to read as follows:
(o) An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This subdivision shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013 and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013.

(p) With respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013.

Further, paragraph (3) of section 65-3.8(b) is amended to read as follows:

(3) Except as provided in subdivision (e) of this section, 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 [section] sections 65-3.5 and 65-3.6 of this Subpart (e.g., medical reports, wage verification, etc.). However, an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart. This subdivision shall not apply to a prescribed form (NF Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This paragraph shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013, and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013.

Technical Defects

Under the current no-fault law, if there is an insignificant, non-substantive or technical defect in an insurer's otherwise presumably valid verification request or denial, the applicant may seek to challenge its legitimacy through the courts or arbitration. In an effort to cut down on what the Department of Financial Services views as unnecessary litigation and delay, the new amendment
explicitly provides that an applicant's obligation to comply with a notice or verification request is not negated—and a denial of claim is not invalidated—due to a non-substantive technical or immaterial defect contained in any of these documents.

With regard to a denial of claim form (NYS Form NF-10), subsection 65-3.8 (h) provides that "an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim. The subdivision will be applicable to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013." With respect to a verification request and notice, subsection 65-3.5(p) provides that "an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013."