

Insurance Department

EMERGENCY RULE MAKING

Processing of Claims

I.D. No. INS-34-06-00001-E

Filing No. 937

Filing date: Aug. 2, 2006

Effective date: Aug. 2, 2006

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Addition of Part 56 (Regulation 183) to Title 11 NYCRR.

Statutory authority: Insurance Law, sections 201, 301, 1109, 3201, 3216, 3217, 3221, 4235, 4303, 4304, 4305 and 4802; and art. 49

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: Insurance Law and regulations require certain health insurance policies to provide coverage for surgical services. 11 NYCRR 52.16(c)(5) permits insurers to exclude coverage for surgery that is considered to be cosmetic. Articles 49 of the Insurance Law and Public Health Law, enacted after Section 52.16, provide for internal and external appeal when services are denied as not medically necessary.

It is the Insurance Department's position that whenever surgery is a covered benefit under a policy, a determination that the surgery is cosmetic is a medical necessity determination subject to the utilization review and external review requirements of Title I and Title II of Article 49 of the Insurance Law or Public Health Law. It has come to the Department's attention that insurers and health maintenance organizations (HMOs) have been inconsistent as to what they consider to be medically necessary surgery or cosmetic surgery and some insureds have not been provided with the right to utilization review and external appeal for denial of surgical services. If the appropriate appeal rights are not given, an insured may be unable to obtain medically necessary health care services, adversely affecting the health of the insured.

To establish uniformity, ensure that consumers are protected, and address concerns of health plans, a new Part 56 is added to 11 NYCRR and the cosmetic surgery exclusion in Part 52.16(c)(5) is amended. These two regulations clarify that denials for the reason that services are considered cosmetic are subject to the utilization review and external appeal requirements of Article 49 of the Insurance Law or Public Health Law. Part 56 further provides that a request for coverage of surgery, other than a request for pre-authorization, that is solely identified by a code on a designated list, and is submitted without medical information, may be denied by a health plan without subjecting the request to Title I and Title II of Article 49 of the Insurance Law or Public Health Law if certain conditions are met.

The requirements established in these regulations are the result of a collaborative effort among the New York Health Plan Association, the New York State Conference of Blue Cross and Blue Shield Plans, the New York State Department of Health and the New York State Insurance Department. Health plans are aware of the requirements in these regulations and have advised the Insurance Department that they would like to begin implementation through revised subscriber contracts. The Insurance Department has already received and approved subscriber contracts from health plans that include the process outlined in Part 56 and the amended Part 52. Promulgating Part 56 and the amended Part 52 on an emergency basis will ensure that all subscriber contracts that are being filed and approved are consistent with regulatory requirements and will enable health plans to make all contract changes in one filing.

Moreover, these amendments will ensure that all health plans are following the same requirements and that access to utilization review and external appeal by insureds will not be dependent on the particular health insurance policy the insured may have. These amendments will further ensure that insureds will be able to obtain medically necessary surgical services so that the health of insureds is not compromised.

For the reasons stated above, the immediate adoption of this regulation is necessary for the preservation of the general welfare.

Subject: Rules relating to processing of claims

Purpose: To clarify when plans may exclude coverage for cosmetic surgery

Text of emergency rule: A new Part 56 of Title 11 NYCRR (Regulation No. 183) is adopted to read as follows:

Section 56.0 Preamble. Section 52.16(c)(5) of Part 52 of this Title (Regulation 62), permits insurers and health maintenance organizations (HMOs) that are required to provide coverage for surgical services, to exclude coverage of cosmetic surgery. Part 52 does not define cosmetic surgery, but does provide examples of two types of reconstructive surgeries that may never be considered cosmetic. Subsequent to the promulgation of Part 52, Title I and Title II of Article 49 of the Insurance Law and Public Health Law were enacted that require medical necessity denials to be subject to utilization review and external appeal. The Insurance Department has found inconsistencies among insurers and HMOs as to when denials of surgery are considered medical necessity denials and subject to utilization review and external appeal. Section 56.3 of this Part and an amended section 52.16(c)(5) of Part 52 of this Title clarify that, whenever surgery is a covered benefit under certain policies, a determination that the surgery is cosmetic is a medical necessity determination subject to the utilization review and external review requirements of Titles I and II of Article 49 of the Insurance Law and Public Health Law, except in certain cases when the claim or request for surgery is identified by one of the codes in subdivision (f) of section 56.3 of this Part and is submitted without medical information.

Section 56.1 Applicability. This Part shall be applicable to policies that provide hospital, surgical or medical expense coverage.

Section 56.2 Definitions. The following words or terms shall have the following meanings when used in this Part:

(a) Health care professional means an appropriately licensed, registered or certified health care professional pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

(b) Health care provider means a health care professional or a facility licensed pursuant to article 28, 36, 44 or 47 of the public health law or a facility licensed pursuant to article 19, 23, 31 or 32 of the mental hygiene law.

(c) Health plan means an insurer or health maintenance organization (HMO) that has issued a policy that provides hospital, surgical or medical expense coverage.

(d) Medical information means any medical data, written explanation from a health care professional, or medical record.

Section 56.3 Claim review requirements for surgical services.

(a) A claim or request for coverage of reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect shall not be considered by a health plan to be cosmetic. Reconstructive surgery may however be reviewed for medical necessity subject to the requirements of Title I and Title II of Article 49 of the Insurance Law or Public Health Law.

(b) A claim or request for coverage of surgery other than for the surgical services described in subdivision (a) or (c) of this section that is considered by a health plan to be cosmetic shall be reviewed for medical necessity subject to the requirements of Title I and Title II of Article 49 of the Insurance Law or Public Health Law.

(c) A claim or request for coverage of surgery, other than a request for pre-authorization, that is solely identified by one of the codes in subdivision (f) of this section and is submitted to a health plan without any accompanying medical information, may be denied by a health plan as cosmetic without subjecting the request to the requirements of Title I and Title II of Article 49 of the Insurance Law or Public Health Law, provided that:

(1) notice of the denial includes a clear statement describing the basis for the denial;

(2) notice of the denial includes a statement that the insured has a right to a medical necessity review if the insured or the insured's health care provider believes the claim or request involves issues of medical necessity and submits medical information;

(3) if a medical necessity review is requested and medical information is submitted, the health plan treats the request as a utilization review appeal pursuant to section 4904 of the Insurance Law or Public Health Law; and

(4) if the health plan denies coverage of the procedure after receipt of medical information, the health plan issues a final adverse determination in compliance with section 4904(c) of the Insurance Law and section

410.9(e) of Part 410 of this Title (Regulation 166) or section 4904(3) of the Public Health Law and 10 NYCRR 98-2.9(e), as applicable.

(d) If an initial claim or request for a procedure listed in subdivision (f) of this section is submitted to a health plan with accompanying medical information, the claim or request shall be reviewed in compliance with Title I and Title II of Article 49 of the Insurance Law or Public Health Law.

(e) If an initial claim or request for a procedure listed in subdivision (f) of this section is submitted to a health plan as a pre-authorization request without accompanying medical information, the necessary information shall be requested as required by section 4905(k) of the Insurance Law or section 4905(11) of the Public Health Law and the claim or request shall be reviewed in compliance with Title I and Title II of Article 49 of the Insurance Law or Public Health Law.

(f) Common Procedural Terminology (CPT code [copyright] and Description

11200 Removal of skin tags, multiple fibrocuteaneous tags, any area; up to and including 15 lesions

11201 Removal of skin tags; each additional 10 lesions

11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less

11951 Subcutaneous injection of filling material (eg, collagen), 1.1 to 5.0 cc

11952 Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc

11954 Subcutaneous injection of filling material (eg, collagen); over 10.0 cc

15775 Punch graft for hair transplant; 1 to 15 punch grafts

15776 Punch graft for hair transplant; more than 15 punch grafts

15780 Dermabrasion; total face (e.g. for acne scarring, fine wrinkling, rhytids, general keratosis)

15781 Dermabrasion, segmental, face

15782 Dermabrasion, regional, other than face

15783 Dermabrasion, superficial, any site, (eg, tattoo removal)

15786 Abrasion; single lesion (eg, keratosis, scar)

15787 Abrasion; each additional four lesions or less

15788 Chemical peel, facial; epidermal

15789 Chemical peel, facial; dermal

15790 Chemical peel; total face

15791 Chemical peel; face, hand or elsewhere

15792 Chemical peel, nonfacial; epidermal

15793 Chemical peel, nonfacial; dermal

15810 Salabrasion; 20 sq cm or less

15811 Salabrasion; over 20 sq cm

15819 Cervicoplasty

15820 Blepharoplasty, lower eyelid;

15821 Blepharoplasty, lower eyelid; with extensive herniated fat pad

15824 Rhytidectomy; forehead

15825 Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)

15826 Rhytidectomy; glabellar frown lines

15828 Rhytidectomy; cheek, chin, and neck

15829 Rhytidectomy; superficial musculoaponeurotic system (SMAS)

flap

15832 Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh

15833 Excision, excessive skin and subcutaneous tissue (including lipectomy); leg

15834 Excision, excessive skin and subcutaneous tissue (including lipectomy); hip

15835 Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock

15836 Excision, excessive skin and subcutaneous tissue (including lipectomy); arm

15837 Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand

15838 Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad

15839 Excision, excessive skin and subcutaneous tissue (including lipectomy); other area

15876 Suction assisted lipectomy; head and neck

15877 Suction assisted lipectomy; trunk

15878 Suction assisted lipectomy; upper extremity

15879 Suction assisted lipectomy; lower extremity

17340 Cryotherapy (CO2 slush, liquid N2) for acne

17360 Chemical exfoliation for acne (eg, acne paste, acid)

17380 Electrolysis epilation, each 1/2 hour

19316 Mastopexy

19355 Correction of inverted nipples

21120 Genioplasty; augmentation (autograft, allograft, prosthetic material)

30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk

36469 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face

36470 Injection of sclerosing solution; single vein

36471 Injection of sclerosing solution; multiple veins, same leg

69090 Ear piercing

69300 Otoplasty, protruding ear, with or without size reduction

S0500 Laser in situ keratomileusis

S0810 Photorefractive keratectomy

S0812 Phototherapeutic keratectomy

65760 Keratomileusis

65765 Keratophakia

65767 Epikeratoplasty

65771 Radial keratotomy

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This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire October 30, 2006.

Text of emergency rule and any required statements and analyses may be obtained from: Michael Barry, Insurance Department, 25 Beaver St., New York, NY 10004, (212) 480-5262, e-mail: mbarry@ins.state.ny.us

Consolidated Regulatory Impact Statement

1. Statutory Authority: The Superintendent's authority for the addition of Part 56 to Title 11 of NYCRR (Regulation 183) and for the Thirty-fifth Amendment to Part 52 of Title 11 NYCRR (Regulation 62) is derived from Sections 201, 301, 1109, 3201, 3216, 3217, 3221, 4235, 4303, 4304, 4305 and 4802 and Article 49 of the Insurance Law.

Sections 201 and 301 authorize the Superintendent to prescribe regulations interpreting the provisions of the Insurance Law as well as effectuating any power granted to the Superintendent under the Insurance Law, to prescribe forms or otherwise to make regulations.

Section 1109 authorizes the Superintendent to promulgate regulations affecting HMOs and effectuating the purposes and provisions of the Insurance Law and Article 44 of the Public Health Law.

Section 3201 authorizes the Superintendent to approve accident and health insurance policy forms for delivery or issuance for delivery in this state.

Sections 3216 and 3217 authorize the Superintendent to issue regulations to establish minimum standards for the form, content and sale of health insurance. Section 3221 sets forth standard health insurance policy provisions.

Section 4235 establishes requirements for group accident and health insurance.

Article 43 of the Insurance Law sets forth requirements for non-profit medical and dental indemnity corporations and non-profit health or hospital corporations, including requirements pertaining to minimum benefits of individual and small group contracts. Sections 4303, 4304 and 4305 set forth required benefits and standard provisions in group, blanket and group remittance contracts.

Section 4802 establishes the grievance procedures for all insurers which offer a managed care product.

Article 49 establishes the utilization review and external review requirements for all insurers subject to Article 32 or 43 of the Insurance Law or any organization licensed under Article 43 of the Insurance Law.

2. Legislative Objectives: The statutory sections mentioned above contain standard provisions for accident and health insurance coverage and set forth the Superintendent's power to promulgate regulations governing minimum standards for the form, content and sale of such coverage. The promulgation of Regulation 183 and the amendment to Section 52.16(c)(5) of Regulation 62 further the legislative goal of having meaningful health insurance coverage available to the insurance-buying public in this state while at the same time providing reasonable regulation to ensure consistency in the application of permissible exclusions in such coverage.

The cosmetic surgery exclusion set forth in Regulation 62 predates Article 49 of the Insurance Law and Article 49 of the Public Health Law

which provide for internal and external appeal of medical necessity denials. Subsequent to the promulgation of Article 49, the Insurance Department has found inconsistencies among health maintenance organizations (HMOs) and insurers as to what they consider to be medically necessary surgery and what they consider to be cosmetic. The Insurance Department and Health Department have advised health plans that cosmetic surgery denials must be subject to the utilization review and external review requirements. However, some health plans have questioned the Department's position in cases involving procedures usually considered to be cosmetic when medical information is not submitted.

By clarifying the requirements relating to the cosmetic surgery exclusion, the Superintendent is furthering the legislative intent set forth in Article 49 of the Insurance Law and Article 49 of the Public Health Law which require health plans to conduct utilization reviews to determine if services are medically necessary, and then provide external appeal rights if services are denied. The amendment of Regulation 62, and the addition of new Regulation 183, is necessary to establish uniformity among health plans and ensure that cosmetic surgery denials are given the appropriate review.

3. Needs and Benefits: The Insurance Law and corresponding regulations require most insurers to provide coverage for surgical services. 11 NYCRR 52.16(c)(5) permits plans to exclude coverage for cosmetic surgery but provides an exception to the cosmetic surgery exclusion for reconstructive surgery. However, the reconstructive surgery exception is not the only type of surgery that would not be cosmetic. The amendment to Regulation 62 and the new Regulation 183 clarify that whenever surgery is a covered benefit, a determination that the surgery is cosmetic is a medical necessity determination that must be subject to the utilization review and external appeal requirements of Article 49 of the Insurance Law or Public Health Law.

To address the concerns of health plans that certain procedures usually considered cosmetic would be subject to the utilization review and external review requirements when medical information is not submitted, Part 56 further provides that a request for coverage of surgery, other than a request for pre-authorization, that is solely identified by a code on a designated list, and is submitted without medical information, may be denied by a health plan without subjecting the request to Title I and Title II of Article 49 of the Insurance Law and Public Health Law. However, if a request for surgery identified by a code on the designated list is submitted with medical information, or as a preauthorization request, then the Article 49 utilization review process must be followed to adjudicate the claim. In addition, if the automatic denial process is used for the designated codes, the denial must explain that the insured may request a medical necessity review and submit medical information, in which case the plan must review as a utilization review appeal and provide external appeal rights.

The requirements established in these regulations, and the list of procedures set forth in Table I of the new Regulation 183, are the result of a collaborative effort among the New York Health Plan Association, the New York State Conference of Blue Cross and Blue Shield Plans, the New York State Department of Health and the New York State Insurance Department. Interested parties agreed that it is in the best interest of both health plans and consumers for there to be uniformity among the plans when making coverage decisions, and these regulations are intended to establish such uniformity. Representatives of insurers and HMOs also expressed concern about the cost of a clinical peer review when services usually considered to be cosmetic are reviewed retrospectively and medical information has not been submitted. The list of procedures in Regulation 183 that may be denied without such review addresses this concern while still ensuring that consumer utilization review and external appeal rights are not compromised. Striving to minimize the costs of health insurance and protecting the interests of consumers who purchase health insurance are important functions of the Superintendent. These regulations accomplish both and ensure that there is uniformity among health plans when making coverage determinations.

4. Costs: The regulations apply only to insurers and HMOs issuing insurance policies that exclude cosmetic surgery. Any costs imposed on regulated parties as a result of the regulations will be minimal as they involve only clarification of existing optional insurance policy provisions. Actual costs to insurers and HMOs will be limited to the time that product compliance personnel will spend in implementing any accompanying changes to their claims procedure or making any filings.

The regulations may indirectly affect health care providers since the regulations clarify that medical information must be submitted by providers or their patients for certain health care procedures usually considered to

be cosmetic. However, current law permits insurers and HMOs to request medical information in order to make a claim determination.

The costs to the Insurance Department will be limited to the time spent by existing staff to review products submitted by insurers for compliance.

There should be no costs associated with these regulations to state or local government.

5. Local Government Mandates: The regulations impose no new programs, services, duties or responsibilities on any county, city, town, village, school district or fire district.

6. Paperwork: The regulations do not impose any additional paperwork requirements on insurers or HMOs. Insurers and HMOs are currently required by law to make form and utilization review report filings with the Department. HMOs and insurers are also currently permitted to request medical information from providers and consumers and therefore it is unlikely that any greater burden would be imposed on providers or consumers.

7. Duplication: The regulations do not duplicate standards of either the federal or other state governments. The regulations set standards applicable to health insurance coverage for New York State.

8. Alternatives: The regulations were developed through meetings with interested parties. Alternatives such as precluding plans from denying procedures when medical information is not submitted, or including an expanded list of procedures, were both discussed but the Insurance Department and Health Department determined that the list of procedures included the regulation is the most appropriate to meet the needs of health plans and protect consumers. The Department also considered whether these requirements could be established through guidelines, and determined that regulations would be needed to integrate the new requirements with existing requirements and to ensure uniformity and consistency in application.

9. Federal Standards: The U.S. Department of Labor Claims Payment Regulation, 29 C.F.R. 2560.503 issued pursuant to the Employee Retirement Income Security Act (ERISA) creates federal standards for the treatment of medical necessity denials and the processing of such claims. However, this regulation does not provide any specific federal standards or requirements for the form, content and sale of health insurance coverage for surgical services.

10. Compliance Schedule: Regulated parties should be able to comply with the regulations immediately. Insurers and HMOs have been made aware of the requirements in the regulations through meetings and Department correspondence. In addition, the Insurance Department has always instructed insurers and HMOs that they must treat cosmetic surgery denials as medical necessity denials. The regulations merely clarify this instruction and provide an option for claims processing when medical information is not submitted.

Consolidated Regulatory Flexibility Analysis

1. Effect of the rule: These regulations will affect all health maintenance organizations (HMOs) and insurers licensed to do business in New York State. Based upon information provided by these companies in annual statements filed with the Insurance Department, HMOs and insurers licensed to do business in New York do not fall within the definition of small business found in Section 102(8) of the State Administrative Procedures Act because none of them are both independently owned and have under 100 employees. These regulations may indirectly affect health care providers since the regulations clarify that medical information must be submitted by providers or their patients for certain health care procedures usually considered to be cosmetic. These regulations do not apply to or affect local governments.

2. Compliance requirements: These regulations will not impose any reporting, recordkeeping, or other compliance requirements on small businesses or local governments. Health care providers and consumers requesting coverage of certain procedures usually considered to be cosmetic, other than for requests involving preauthorization, will need to submit medical information, if not previously submitted. However, current law permits insurers and HMOs to request information from providers and consumers in order to make coverage determinations.

3. Professional services: Small businesses or local governments should not need professional services to comply with the regulations.

4. Compliance costs: These regulations will not impose any compliance costs upon small businesses or local governments. The Insurance Law and Public Health Law currently permit health plans to request medical information from providers and their patients in order to make coverage determinations.

5. Economic and technological feasibility: Small businesses or local governments should not incur an economic or technological impact as a result of the regulations.

6. Minimizing adverse impact: These regulations apply to the insurance market throughout New York State. The same requirements will apply uniformly, and do not impose any adverse or disparate impact on HMOs, insurers, health care providers or consumers.

7. Small business and local government participation: These regulations are directed at HMOs and insurers licensed to do business in New York State, none of which fall within the definition of small business as found in Section 102(8) of the State Administrative Act. Notice of the proposal was previously published in the Insurance Department's Regulatory Agenda. This notice was intended to provide small businesses with the opportunity to participate in the rule making process. Interested parties were also consulted through direct meetings during the development of the proposed regulations.

Consolidated Rural Area Flexibility Analysis

1. Types and Estimated Number of Rural Areas: Insurance companies and health maintenance organizations (HMOs) to which these regulations apply do business in every county in this state, including rural areas as defined under State Administrative Procedure Act Section 102(13). Some of the home offices of these companies lie within rural areas. These regulations may also indirectly affect health care providers, including providers located in rural areas; since the regulations clarify that medical information must be submitted by providers or their patients for certain health care procedures usually considered to be cosmetic.

2. Reporting, Recordkeeping and Other Compliance Requirements, and Professional Services: Insurance companies and HMOs may have to modify their claim processing procedures and/or make new filings to the Insurance Department to conform to the regulations. No professional services will be necessary to comply with the proposed rule. Health care providers and consumers requesting coverage of certain procedures usually considered to be cosmetic, other than for requests involving preauthorization, will need to submit medical information, if not previously submitted. However, current law permits insurers and HMOs to request information from providers and consumers in order to make coverage determinations.

3. Costs: The costs to regulated parties as a result of the regulations will be limited to the costs associated with the time that product compliance personnel will spend in implementing any modified claims procedures, or making any necessary filings.

4. Minimizing Adverse Impact: These regulations apply uniformly to entities that do business in both rural and nonrural areas of New York State. These regulations do not impose any additional burden on persons located in rural areas and the Insurance Department does not believe that the regulations will have an adverse impact on rural areas.

5. Rural Area Participation: Notice of the regulations was published in the Insurance Department's Regulatory Agenda. Although there was no specific effort to obtain rural area input during the development of the regulations, interested parties, including health plan representatives, were consulted through direct meetings during the development of the regulations.

Consolidated Job Impact Statement

This proposed addition of a new Part 56 and the Thirty-fifth Amendment to Part 52 of 11 NYCRR will not adversely impact job or employment opportunities in New York. It is likely to have no impact as it merely involves a slight modification to existing health insurance policy provisions and the associated claims processing procedures.