

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
SECOND AMENDMENT TO
REGULATION NO. 178
(11 NYCRR 217)
PROCESSING OF HEALTH INSURANCE CLAIMS**

I, Eric R. Dinallo, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, 1109, 2403, 3224, and 3224-a of the Insurance Law of the State of New York, do hereby promulgate the second amendment to Part 217 of Chapter IX of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 178), to take effect on July 15, 2009, to read as follows:

Part 217 is hereby retitled: "Processing Of Health Insurance Claims."

Part 217 (Regulation No. 178) is hereby renumbered Subpart 217-1, in sequence. Subpart 217-1 shall be entitled: "Prompt Payment of Health Insurance Claims."

(NEW MATTER UNDERSCORED, DELETED MATTER IN BRACKETS)

New section 217-1.1 is amended to read as follows:

Section 217-1.1 *Definitions and applicability.*

(a) For the purposes of this [Part] Subpart:

(b) This [Part] Subpart shall apply to all health care claims submitted under contracts or agreements issued or entered into pursuant to Articles 32, 42 or 43 of the Insurance Law or Article 44 of the Public Health Law.

New section 217-1.2(d) is amended to read as follows:

(d) Nothing in this [Part] Subpart shall prohibit a payer from electing to accept some or all claims with less information than that specified in the lists set forth in subdivisions (b) and (c) of this section.

A new Subpart 217-2, entitled "**Coordination of Benefit Claims**," is added to read as follows:

(ALL MATTER NEW)

Section 217-2.1 *Definitions and Applicability.*

(a) For purposes of this Subpart:

(1) *Coordination of benefits* or *COB* means a procedure that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more health insurers providing benefits or services for medical, dental or other care or treatment by: establishing an order in which plans pay their claims, providing the authority for the orderly transfer of information needed to pay claims properly and permitting a reduction of the benefits of a health insurer when, by the rules established by Section 52.23 of this Title (Regulation No. 62), it does not have to pay its benefits first.

(2) *Health care claim* means a request for payment for services rendered to an insured pursuant to the benefits provided in a health insurance policy.

(3) *Health care provider* means an entity licensed or certified pursuant to Article 28, 36 or 40 of the Public Health Law; a facility licensed pursuant to Article 19, 23 or 31 of the Mental Hygiene Law; a health care professional licensed, registered or certified pursuant to Title 8 of the Education Law; or a health care provider comparably licensed, registered or certified by another state; or a dispenser or provider of pharmaceutical products, services or durable medical equipment.

(4) *Health insurance policy* means a contract that provides benefits or services for medical, dental or other health care or treatment.

(5) *Health insurer* means an insurer that issues a health insurance policy.

(6) *Remittance advice* means a form on which a health insurer indicates to a health care provider the details of the health insurer's processing of a particular claim.

(7) *Primary health insurer* means a health insurer whose benefits for a person's health care coverage must be determined without taking the existence of coverage issued by any other health insurer into consideration, pursuant to the COB rules in Section 52.23 of this Title and the provisions of the health insurer's policy or contract.

(8) *Secondary health insurer* means a health insurer that is not a primary health insurer that may take into consideration the benefits of the primary health insurer or insurers and the benefits of any other accident and health coverage.

(b) This Subpart shall apply to a health insurer authorized to write accident and health insurance pursuant to Article 42 of the New York Insurance Law, a corporation licensed pursuant to Article 43 of the Insurance Law, or an entity certified pursuant to Article 44 of the Public Health Law, with respect to a health care claim submitted under a health insurance policy. This Subpart shall not apply to coordination of benefits involving no-fault auto insurance policies, workers compensation policies or the Medicare program.

(c) The requirements of this section shall apply when an individual is covered, or where there is a reasonable basis supported by specific information to believe that the individual is covered, under more than one health insurance policy that provides benefits or services for medical, dental or other care or treatment.

Section 217-2.2 *Coordination of benefit requirements.*

(a) When a health care provider submits a claim to a health insurer, that submission shall suspend the time period for submission of the claim to a second health insurer until such time as the provider has received a remittance advice or other evidence of a benefit determination, including an appeal determination, from the first health insurer. After the health care provider receives a remittance advice, appeal determination, or other evidence of a benefit determination from the first health insurer, the health care provider shall have at least 60 days from receipt of the remittance, appeal determination or other evidence of a benefit determination to bill any other health insurer that has a potential payment obligation. A claim submitted to the second health insurer after the 60-day period shall be subject to the claims submission rules of the second health insurer. Unless the health care provider is otherwise able to demonstrate, it shall be presumed that the remittance advice, appeal determination, or other evidence of a benefit determination was received within eight calendar days of the date on the document.

(b) (1) If a health care provider submits a claim to a secondary health insurer prior to submitting the claim to the primary health insurer, the secondary health insurer shall deny the claim, notify the health care provider that it is secondary and notify the health care provider of the identity of the primary health insurer, or, if the identity of the primary health insurer is not known, provide whatever information was used to make the determination that it is a secondary health insurer. The secondary health insurer may provide the information by referring the health care provider to the specific page of the secondary health insurer's website and shall include a toll free telephone number through which the information will be provided. The health care provider's submission of the claim to the primary health insurer shall suspend the time period for resubmission of such claim to the secondary health insurer as set forth above in subdivision (a) of this section.

(2) If the information provided by the secondary health insurer is not sufficient to determine the identity of the primary health insurer, the health care provider shall have 60 days from the notice that other coverage may exist to make a reasonable effort to confirm if other coverage does exist. A "reasonable effort" shall include at least an attempt by the health care provider to contact the patient.

(3) If the health care provider is unable to confirm other coverage within 60 days as provided in paragraph (2) of this subdivision, the secondary health insurer shall process the claim in accordance with the provisions in the health insurance policy, provided that the health care provider resubmits the claim to the secondary health insurer, with copies of the documents to support the health care provider's efforts to confirm other coverage, within 30 days of the determination that other coverage could not be confirmed despite reasonable efforts.

(c) (1) If a secondary health insurer makes a payment to a health care provider prior to determining the secondary health insurer's actual obligation to pay the claim, the secondary health insurer shall delay any action to recover the payment, pending a determination by the primary health insurer as to the primary health insurer's obligation and a determination by the secondary health insurer of its actual obligation to pay the claim. Subject to all provisions of this subdivision, the secondary health insurer may recover the payment if the health care provider does not submit a remittance advice, appeal determination, or other evidence of a benefit determination from the primary health insurer to the secondary health insurer within 120 days of the secondary health insurer's notification that other coverage exists. Nothing herein shall prevent the secondary health insurer from allowing more than 120 days to submit the documents.

(2) If the information provided by the secondary health insurer is not sufficient to determine the identity of the primary health insurer, the health care provider shall have 60 days from the notice that other coverage may exist to make a reasonable effort to confirm if other coverage does exist. A “reasonable effort “ shall include at least an attempt by the health care provider to contact the patient.

(3) If the health care provider is unable to confirm other coverage within 60 days as provided in paragraph (2) of this subdivision, the secondary health insurer shall process the claim in accordance with the provisions in the member’s health insurance policy, provided that the health care provider notifies the secondary health insurer and forwards copies of the documents to support the health care provider’s efforts to confirm other coverage, within 30 days of the determination that other coverage could not be confirmed despite reasonable efforts.

(d) If a health care provider receives approval from a health insurer to provide services to the health insurer’s insured, prior to the rendering of those services to the insured, a second health insurer shall not subsequently deny a claim for the services on the basis that no prior approval from that health insurer was received. The fact that one health insurer has given a health care provider prior approval does not, however, preclude another health insurer from determining that the services that were provided were not medically necessary or otherwise not covered under the policy.

(e) Every determination of the primary health insurer and secondary health insurer shall comply with Section 3224-a of the Insurance Law.

Section 217-2.3 *Effective Date.*

This Subpart shall become effective July 15, 2009, and shall apply to all claims initially submitted on or after that date.

I, Eric R. Dinallo, Superintendent of Insurance of the State of New York, do hereby certify that the foregoing is the second amendment to Part 217 of Chapter IX of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 178), entitled "Processing Of Health Insurance Claims", promulgated by me on March 12, 2009, pursuant to the authority granted by Sections 201, 301, 1109, 2403, 3224, and 3224-a of the Insurance Law, to take effect on July 15, 2009.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on December 24, 2008. No other publication or prior notice is required by statute.

Eric R. Dinallo
Superintendent of Insurance

March 12, 2009