INSURANCE LAW
ARTICLE 32. INSURANCE CONTRACTS--LIFE, ACCIDENT AND HEALTH, ANNUITIES

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NY CLS Ins § 3224-a (2012)

§ 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services

In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to this article and articles [fig 1] forty-two [fig 2] , forty-three and forty-seven of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall adhere to the following standards:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within [fig 1] thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.

(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.

(c) (1) [fig 1] Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

(2) Where a violation of this section is determined by the superintendent as a result of the superintendent's own investigation, examination, audit or inquiry, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall not be subject to a

civil penalty prescribed in paragraph one of this subsection, if the superintendent determines that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section. This paragraph shall not apply to violations of this section determined by the superintendent resulting from individual complaints submitted to the superintendent by health care providers or policyholders.

(d) For the purposes of this section:
(1) "policyholder" shall mean a person covered under such policy or a representative designated by such person; and
(2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen, twenty-three or thirty-one of the mental hygiene law, a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical products, services or durable medical equipment, or a representative designated by such entity or person.

(e) Nothing in this section shall in any way be deemed to impair any right available to the state to adjust the timing of its payments for medical assistance pursuant to title eleven of article five of the social services law, or for child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law or otherwise be deemed to require adjustment of payments by the state for such medical assistance or child health insurance.

(f) In any action brought by the superintendent pursuant to this section or article twenty-four of this chapter relating to this section regarding payments for medical assistance pursuant to title eleven of article five of the social services law, child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law, benefits under the voucher insurance program pursuant to section one thousand one hundred twenty-one of this chapter, and benefits under the New York state small business health insurance partnership program pursuant to article nine-A of the public health law, it shall be a mitigating factor that the insurer, corporation or organization is owed any premium amounts, premium adjustments, stop-loss recoveries or other payments from the state or one of its fiscal intermediaries under any such program.

(g) Time period for submission of claims.
(1) Except as otherwise provided by law, health care claims must be initially submitted by health care providers within one hundred twenty days after the date of service to be valid and enforceable against an insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law. Provided, however, that nothing in this subsection shall preclude the parties from agreeing to a time period or other terms which are more favorable to the health care provider. Provided further that, in connection with contracts between organizations or corporations licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law and health care providers for the provision of services pursuant to section three hundred sixty-four-j or three hundred sixty-nine-ee of the social services law or title I-A of article twenty-five of the public health law, nothing herein shall be deemed: (i) to preclude the parties from agreeing to a different time period but in no event less than ninety days; or (ii) to supersede contract provisions in existence at the time this subsection takes effect except to the extent that such contracts impose a time period of less than ninety days.
(2) This subsection shall not abrogate any right or reduce or limit any additional time period for claim submission provided by law or regulation specifically applicable to coordination of benefits in effect prior to the effective date of this subsection.

(h)
(1) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law shall permit a participating health care provider to request reconsideration of a claim that is denied exclusively because it was untimely submitted pursuant to subsection (g) of this section. The insurer or organization or corporation shall pay such claim pursuant to the provisions of paragraph two of this subsection if the health care provider can demonstrate both that: (i) the health care provider's non-compliance was a result of an unusual occurrence; and (ii) the health care provider has a pattern or practice of timely submitting claims in compliance with subdivision (g) of this section.
(2) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law may reduce the reimbursement due to a health care provider for an untimely claim that otherwise meets the requirements of paragraph one of this subsection by an amount not to exceed twenty-five percent of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing in this subsection shall preclude a health care provider and an insurer or or-

ganization or corporation from agreeing to a lesser reduction. The provisions of this subsection shall not apply to any claim submitted three hundred sixty-five days after the date of service, in which case the insurer or organization or corporation may deny the claim in full.

HISTORY:

Add, L 1997, ch 637, § 3; amd, L 1997, ch 666, § 5, eff Jan 22, 1998.
Opening par, amd, L 1997, ch 666, § 5, eff Jan 22, 1998.
Opening par, amd, L 2009, ch 237, § 6, eff Jan 1, 2010.
The 2009 act deleted at fig 1 "thirty-two" and at fig 2 "and"
Sub (a), amd, L 1997, ch 666, § 5, eff Jan 22, 1998.
Sub (a), amd, L 2009, ch 237, § 6, eff Jan 1, 2010.
The 2009 act deleted at fig 1 "forty-five"
Sub (b), amd, L 1997, ch 666, § 5, eff Jan 22, 1998.
Sub (b), amd, L 2009, ch 237, § 6, eff Jan 1, 2010.
Sub (b), opening par, amd, L 1997, ch 666, § 5, eff Jan 22, 1998.
Sub (b), opening par, amd, L 2009, ch 237, § 6, eff Jan 1, 2010.
Sub (b), closing par, amd, L 1997, ch 666, § 5, eff Jan 22, 1998.
Sub (b), closing par, amd, L 2009, ch 237, § 6, eff Jan 1, 2010.
Sub (c), par (1), formerly entire sub (c), so designated sub (c), par (1) and amd, L 2009, ch 237, § 8, eff July 28, 2009.
Sub (c), par (2), add, L 2009, ch 237, § 8, eff July 28, 2009.
Sub (e), add, L 1997, ch 666, § 5, eff Jan 22, 1998.
Sub (f), add, L 1997, ch 666, § 5, eff Jan 22, 1998.
Sub (g), add, L 2009, ch 237, § 9, eff Jan 1, 2010 (see 2009 note below).
Sub (h), add, L 2009, ch 237, § 9, eff Jan 1, 2010 (see 2009 note below).

NOTES:

Editor's Notes

Laws 2009, ch 237, § 48, sub 6, eff Jan 1, 2010, provides as follows:
48. This act shall take effect January 1, 2010; provided, however, that:
6. provided further that section nine of this act shall apply to dates of service on or after April 1, 2010; and.

Research References & Practice Aids:
68 NY Jur 2d Insurance §§ 18, 43, 54, 55
71 NY Jur 2d Insurance § 2234

LexisNexis 50 State Surveys, Legislation & Regulations

Life Insurance - Sales

Case Notes:

Circular letter issued by Department of Insurance, reminding health maintenance organizations and insurance companies that they were ultimately responsible for compliance with Prompt Pay Law even when they contracted with outside entities for processing of claims and bill payments, did not constitute rule under CLS St Adm P Act § 102 where policy espoused by letter had been followed for at least one year prior to issuance of letter and did not add to or alter provisions of *10 NYCRR 98-1.18(a). N.Y. Health Plan Ass'n v Levin (2001, Sup) 187 Misc 2d 527, 723 NYS2d 819.*

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Department of Insurance did not exceed its statutory authority in issuing circular letter reminding health maintenance organizations (HMOs) and insurance companies that they were ultimately responsible for compliance with Prompt Pay Law even when they contracted with independent practice associations (IPAs) for processing of claims and bill payments, as policy espoused by letter was consistent with Prompt Pay Law and required by *10 NYCRR 98-1.18(a)*, and obligation to pay claims and health provider bills not paid by IPAs was consistent with CLS Pub Health Art 44 and *10 NYCRR 98-1.5(b)(6). N.Y. Health Plan Ass'n v Levin (2001, Sup) 187 Misc 2d 527, 723 NYS2d 819.*

Statement of general policy contained in circular letter issued by Department of Insurance, reminding health maintenance organizations (HMOs) and insurers that they were obligated to pay claims and health provider bills not paid by independent practice associations (IPAs) despite any delegation of claims payment process, was neither arbitrary nor capricious in that insurers, HMOs and IPAs could adequately address potential issues concerning double payments by HMOs and unjustified enrichment to IPAs, and there appeared to be no other mechanism to enforce Prompt Pay Law against *IPAs. N.Y. Health Plan Ass'n v Levin (2001, Sup) 187 Misc 2d 527, 723 NYS2d 819.*

While the Prompt Pay Law, N.Y. *Ins. Law § 3224-a*, afforded a private right of action to a hospital, as an intended beneficiary of the statute, to seek payment directly from an insurer, because the hospital relied upon the breach of existing patient contracts, it was precluded from asserting an unjust enrichment claim. *Maimonides Med. Ctr. v First United Am. Life Ins. Co. (2012, Sup) 941 NYS2d 447.*

Interest rate insurer is required to pay for overdue accident and health insurance claims is 12 percent. Insurance Department, Opinions of General Counsel, Opinion Number 01-10-16.

Requirements of *CLS Ins § 3224-a* are applicable if claim is being denied because it is submitted beyond certain time period after date of service ("stale claim"). Insurance Department, Opinions of General Counsel, Opinion Number 01-09-06.

"Payment" within context of *CLS Ins § 3224-a* is made when insurer issues check, and places such check in mail, or personally delivers it. Insurance Department, Opinions of General Counsel, Opinion Number 02-01-13.

Physician's claim that has been filed electronically through electronic clearinghouse employed by physician that rejects such claim, and does not forward such claim to intended insurer or health maintenance organization (HMO), does not constitute receipt of claim by insurer or HMO under *CLS Ins § 3224-a*. Insurance Department, Opinions of General Counsel, Opinion Number 02-01-18.

Physician's claim that has been filed electronically through electronic clearinghouse employed by physician, which successfully forwards such claim to intended insurer or health maintenance organization (HMO), constitutes receipt of claim by insurer or HMO under *CLS Ins § 3224-a*. Insurance Department, Opinions of General Counsel, Opinion Number 02-01-18.

Physician's claim that has been filed electronically through electronic clearinghouse employed by physician that rejects such claim, and does not forward such claim to intended insurer or HMO, does not constitute receipt of claim by insurer or HMO under *CLS Ins § 3224-a*. Insurance Department, Opinions of General Counsel, Opinion Number 02-01-18.

Physician's claim that has been filed electronically through electronic clearinghouse employed by physician, which successfully forwards such claim to intended insurer or HMO, constitutes receipt of claim by insurer or HMO under *CLS Ins § 3224-a*. Insurance Department, Opinions of General Counsel, Opinion Number 02-01-18.

CLS Ins § 3224-a does not require insurer or health maintenance organization to be responsible for making payments to health care providers, where health care provider has contractually agreed to look solely to third party for payment. Insurance Department, Opinions of General Counsel, Opinion Number 02-02-14.

Health claims are required to be paid by health insurance companies within 45 days of receipt of such claim (*CLS Ins § 3224-a*), and motor vehicle no-fault providers are required to pay health claims arising from vehicular accidents within 30 days of receipt of such claim (*CLS Ins § 5106*); there is no New York statutory definition of "clean claim." Insurance Department, Opinions of General Counsel, Opinion Number 02-07-22.

Interest rate for violation of payment deadlines that is imposed on health insurers and health maintenance organizations is set by *CLS Ins § 3224-a(c)*, and interest rate for violation of payment deadlines of health claims arising from vehicular accidents is set by *CLS Ins § 5106*; further, *CLS Ins § 2406* provides that Superintendent of Insurance may impose fines for certain violations of Insurance Law. Insurance Department, Opinions of General Counsel, Opinion Number 02-07-22.

Denial of payment by insurance company or health maintenance organization for services by non-participating health care provider as "assistant surgeon" is subject to utilization review procedures of CLS Insurance Law Art 49 and CLS Public Health Law; if health care provider is participating provider, he or she is not entitled to statutory utilization review procedures since provider's rights are governed by contract between insurer and health care provider. Insurance Department, Opinions of General Counsel, Opinion Number 02-09-18.

When insurer mistakenly denies claims because of claims-processing error, and such claims are not paid within statutory time frame, such denials are violations of *CLS Ins § 3224-a*; interest should be calculated from point to 45 days after date claim was originally received under *CLS Ins § 3224-a(c)*. Insurance Department, Opinions of General Counsel, Opinion Number 03-04-30.

New York Prompt Pay Law (*CLS Ins § 3224-a*) has not been preempted by enactment of federal Medicare Prescription Drug, Improvement and Modernization Act (MMA); since Prompt Pay Law did not previously regulate payments under Medicare+Choice program, any change in federal statutes is of no effect in this regard. Insurance Department, Opinions of General Counsel, Opinion Number 04-06-18.

If pharmacist has contracted with insurer to provide prescription drugs to insurer's insureds or subscribers and contract provides that pharmacist will grant volume or prompt pay discounts, such action does not affect pharmacist's Usual Customary and Reasonable (UCR) charges with respect to other insurers, where pharmacist is not participating provider, provided pharmacist does not conceal such discounts. Insurance Department, Opinions of General Counsel, Opinion Number 04-08-36.

Health care provider may offer discounts to insurer provided that discounts are "transparent," i.e. another insurer is or can become aware of existence of and conditions of discount to first insurer, so that second insurer may reflect any discount in its calculation of usual customary and reasonable (UCR) charges. Insurance Department, Opinions of General Counsel, Opinion Number 04-08-36.

Payments to participating health care provider from health maintenance organization (HMO) with Certificate of Authority from Commissioner of Health for services rendered to subscriber of another HMO are not subject to requirements of Prompt Pay Law (*CLS Ins § 3224-a*) where second HMO is not licensed in New York. Insurance Department, Opinions of General Counsel, Opinion Number 04-10-19.

CLS Ins § 3224-a does not specifically preclude insurer from auditing claims submitted by health care provider, for which it has already made payment. Insurance Department, Opinions of General Counsel, Opinion Number 05-09-06.

With respect to participating healthy care providers, contract between health care provider and insurer, including Health Maintenance Organization, would control how far back insurer could audit claims; with respect to non-participating health care providers, there is no provision in Insurance Law or regulations promulgated thereunder imposing any such limitation. Insurance Department, Opinions of General Counsel, Opinion Number 05-09-10.

If insurer, including HMO, were to conduct retrospective audits as general practice (1) to avoid either paying claims or providing services covered under contract, or (2) in retaliation for health care provider leaving network, Insurance Department would investigate and take necessary action against insurer or HMO. Insurance Department, Opinions of General Counsel, Opinion Number 05-09-10.

Health insurer that requests "medical necessity" documentation more than 30 days after receiving health care provider's bill for rendered services violates *CLS Ins § 3224-a* if insurer does not make payment within 45 days of receipt of bill. Insurance Department, Opinions of General Counsel, Opinion Number 07-12-03.

Under *CLS Ins § 3224-a(c)*, penalty may be imposed on insurer that does not pay health care services bill within 45 days of its receipt and requests additional documentation more than 30 days after receiving bill. Insurance Department, Opinions of General Counsel, Opinion Number 07-12-03.

Insurer may make payments only for credit to insured employee without violating *CLS Ins § 4235(e)* if insurer can show that direct payment of short term disability proceeds (1) will go to disabled employee and will not inure to benefit of employer, (2) is discretionary on part of employee, and (3) would be made in manner that insurer was in compliance with *CLS Ins § 3224-a* with respect to prompt payment of claims. Insurance Department, Opinions of General Counsel, Opinion Number 08-03-03.

With regard to retroactive payment of adjusted diagnosis related group (DRG) rates, *CLS Ins § 3224-a* is triggered when insurer receives adjusted bill for services rendered from hospital; at that point, insurer has 45 days to retroactively pay adjusted DRG rates to hospital, but even in absence of adjusted bill for services rendered, insurer should, in expeditious manner, retroactively adjust payments in accordance with any requirements established by state Department of Health. Insurance Department, Opinions of General Counsel, Opinion Number 08-06-10.