

Insurance Circular Letter No. 17 (2020): Coronavirus and the Suspension of Certain Utilization Review and Notification Requirements under the “Surge and Flex” Protocol | Department of Financial Services (function (w, d, s, l, i) { w[l] = w[l] || []; w[l].push({'gtm.start': new Date().getTime(), event: 'gtm.js'}); var f = d.getElementsByTagName(s)[0], j = d.createElement(s), dl = l != 'dataLayer' ? '&l=' + l : ''; j.async = true; j.src = 'https://www.googletagmanager.com/gtm.js?id=' + i + dl; f.parentNode.insertBefore(j, f); })(window, document, 'script', 'dataLayer', 'GTM-M4THFPF'); Skip to main content var _NY = { HOST: "static-assets.ny.gov", BASE_HOST: "www.ny.gov", hideSettings: false, hideSearch: true, showLanguageHeader: true, showLanguageFooter: true, }; DFS Global Navigation Header Department of Financial Services Consumer Information Consumer Information Auto Insurance Banking and Sending Money Disaster and Flood Resources Drug Prices and PBMs Fraud and Cyber Protection Healthcare Homeowners & Tenants Small Business Resources Student Loan Resources and Relief More... Applications & Filings Applications & Filings Application Fees & Assessments Pharmacy Benefit Managers Banks and Trusts Insurance Agents & Brokers Insurance Companies Mortgage Companies Virtual Currency Businesses More... Industry Guidance Industry Guidance Cybersecurity Resource Center Climate Change Diversity, Equity and Inclusion Innovation Health Equity Enforcement & Discipline Circular Letters Industry Letters Regulatory & Legislative Activities Reports & Publications Reports & Publications Newsroom Examinations & Exam Reports DFS Annual Reports Other Reports Hearings Weekly Bulletins About Us About Us Contact Us File a Complaint or Appeal Careers With DFS Newsroom Procurement <form accept-charset="UTF-8" action="/search/site" method="get" class="d-flex" role="search" id="dfs-site-search-form"> Search <input id="dfs-site-search-input" name="search" class="form-control pe-5 nav-searchbar" type="search" placeholder="Search DFS" aria-label="Search" required> <button type="submit" class="btn btn-search position-absolute end-0 top-0" aria-label="Submit search"> Submit search DFS Portal Home Industry Guidance Circular Letters Insurance Circular Letter No. 17 (2020): Coronavirus and the Suspension of Certain Utilization Review and Notification Requirements under the “Surge and Flex” Protocol Insurance Circular Letter No. 17 (2020) December 23, 2020

To: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans, Prepaid Health Services Plans, Utilization Review Agents, and Licensed Independent Adjusters

Re: Coronavirus and the Suspension of Certain Utilization Review and Notification

Requirements under the “Surge and Flex” Protocol

STATUTORY REFERENCES: N.Y. Insurance Law §§ 3216, 3217-b, 3221, 4303, 4325, 4902, and 4903; Public Health Law §§ 4406-c, 4902, and 4903; Part YY of Chapter 56 of the Laws of 2020; and Executive Order 202, as extended

I. Purpose In response to the coronavirus disease 2019 (“COVID-19”) pandemic, the Governor of New York declared a disaster emergency pursuant to Executive Order 202, which has been extended. COVID-19 has spread to millions of people worldwide, with approximately 850,000 confirmed cases in New York State. COVID-19 has devastated communities and has strained health care delivery systems. On December 7, 2020, the Governor announced the “Winter COVID-19 Plan” and directed the New York State Department of Health (“DOH”) to implement the state’s “surge and flex” protocol mandating all hospitals to begin expanding their bed capacity to prepare for a COVID-19 surge. To implement the “surge and flex” protocol, hospitals will need to be ready to quickly transfer patients between hospitals and, when appropriate, discharge patients to skilled nursing facilities or their homes in order to increase bed capacity and balance patient load. Against this backdrop, existing rules for preauthorization for certain services may hinder efforts by hospitals to rapidly transfer or discharge patients. The purpose of this circular letter is to advise insurers authorized to write accident and health insurance in this state, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans with respect to commercial coverage, Child Health Plus, Essential Plan, and Medicaid managed care coverage (collectively “issuers”), independent agents performing utilization review under contract with such issuers, and licensed independent adjusters, that certain utilization review and notification requirements must be suspended for 60 days starting from the date of this letter, to assist hospitals with implementation of the state’s “surge and flex” protocol.

II. Suspension of Preauthorization Requirements for Scheduled Inpatient Surgeries and Inpatient Admissions at Hospitals To implement the state’s “surge and flex” protocol, hospitals will need to rapidly admit and treat insureds who need urgent or non-elective inpatient hospital services, including inpatient surgeries. Insurance Law and Public Health Law §§ 4903 permit issuers to require preauthorization for health care services, other than emergency services. However, hospitals need flexibility to quickly provide urgent and non-elective inpatient hospital services, including inpatient surgeries, in order to maximize hospital capacity. Therefore, the Department of Financial Services (“Department”) is directing issuers to suspend preauthorization for urgent or non-elective scheduled inpatient surgeries or inpatient admissions at hospitals for 60 days starting from the date of this letter. However, a hospital should use its best efforts to provide 48 hours’ notice to the issuer after the admission to a hospital, including information necessary for an issuer to assist in coordinating care and discharge planning. Issuers may review these services for medical necessity concurrently or retrospectively. This suspension of preauthorization review does not apply to “non-essential elective procedures” that can be delayed in accordance with DOH’s

“COVID-19 Directive Regarding the Resumption of Elective Outpatient Surgeries and Procedures in General Hospitals in Counties and Facilities Without a Significant Risk of COVID-19 Surge,” dated April 29, 2020 (the “DOH directive”). Non-essential elective procedures include those described in Tiers 1a and 1b of Attachment A of the DOH directive (“Attachment A”) and in Tiers 2a and 2b of Attachment A if, in the clinical judgment of the insured’s physician, a delay will not worsen the insured’s morbidity or impact mortality.

III. Suspension of Preauthorization Requirements for Insured Transfers Between Hospitals
To implement the state’s “surge and flex” protocol, hospitals will also need to be prepared to rapidly transfer insureds to a hospital within the same hospital system or to a hospital outside their system in order to balance patient load. Insurance Law and Public Health Law §§ 4903 permit issuers to require preauthorization for health care services, other than emergency services. However, hospitals need flexibility to quickly transfer insureds between hospitals, either within the same hospital system or to another hospital, to ensure that a particular hospital experiencing a higher patient volume is not overwhelmed. Therefore, the Department is directing issuers to suspend preauthorization review for hospital transfers for 60 days starting from the date of this letter. However, a hospital should use its best efforts to provide 48 hours’ notice to the issuer after the transfer, including information necessary for an issuer to assist in coordinating care and discharge planning. Hospitals should also use their best efforts to transfer insureds to in-network hospitals. Preauthorization may continue to be required for non-emergency air transport. To the extent that they have not already done so, hospitals and issuers are encouraged to work collaboratively to resolve issues relating to payment for hospital transfers. To the extent that an issuer and hospital have a contract in place that addresses a transfer either within the hospital system or between other hospitals, the contract will govern the billing for such transfer. If an issuer does not have a contract with a hospital that addresses such transfers, the issuer and hospital should work in good faith to determine the appropriate policies and payment for the transferring or the receiving hospital, including whether the stay should be considered a short stay. In the absence of contract language providing for a transfer payment policy, payments for transfers involving Medicaid managed care insureds should be guided by Medicaid fee-for-service program policies. An insured who is transferred by a participating hospital or who obtains emergency services should be only responsible for the in-network cost-sharing. Issuers may review these services for medical necessity concurrently or retrospectively.

IV. Suspension of Preauthorization for Inpatient Rehabilitation Services Following an Inpatient Hospital Stay
Insurance Law § 4903(b)(1) and Public Health Law § 4903(2)(a) require issuers to make a determination on health care services that require preauthorization within three business days from receipt of the necessary information. Pursuant to Part YY of Chapter 56 of the Laws of 2020, for services provided on or after January 1, 2021, issuers must make a determination on a preauthorization request for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility within one business day of receipt of the necessary information. In order to enable hospitals to implement the state’s “surge and flex” protocol and readily discharge insureds to lower

levels of care when medically appropriate, the Department is directing issuers to suspend preauthorization requirements for inpatient rehabilitation services following a hospital admission for 60 days starting from the date of this letter. Issuers should provide hospitals with an up-to-date list of all in-network rehabilitation facilities and skilled nursing facilities in order to facilitate such discharges. Hospitals should use their best efforts to transfer insureds to in-network providers. An issuer may require the rehabilitation facility or skilled nursing facility to provide notification of the admission to the issuer. Issuers may review inpatient rehabilitation services for medical necessity concurrently or retrospectively. Issuers are also reminded that Insurance Law §§ 3217-d(d), 4306-c(d), and 4804(a) and Public Health Law § 4403(6) require an issuer that does not have an in-network provider, including an inpatient rehabilitation services provider, able to accept the insured, to provide access to an out-of-network provider at the in-network cost-sharing. For 60 days starting from the date of this letter, issuers, rehabilitation facilities, and skilled nursing facilities should adhere to the following procedures for inpatient rehabilitation services following a hospital admission if an in-network provider is not able to accept the insured. It is DOH's expectation that out-of-network rehabilitation facilities and skilled nursing facilities will use their best efforts to provide notice to the issuer within 48 hours of the admission. Issuers should negotiate a rate with the out-of-network facility within 48 hours from the notification. If no agreement is reached, the issuer should reimburse an out-of-network facility providing inpatient rehabilitation services for Medicaid managed care enrollees at the Medicaid fee-for-service rate. An issuer should reimburse an out-of-network facility providing inpatient rehabilitation services for insureds covered under individual or group comprehensive health insurance policies or contracts at the lesser of: (a) the issuer's prevailing in-network reimbursement rate for such services with respect to insureds covered under such policies or contracts or (b) the Medicare reimbursement rate for such services. It is DOH's expectation that a rehabilitation facility or skilled nursing facility will not balance bill insureds for such services other than for the insured's in-network cost-sharing.

V. Suspension of Preauthorization for Home Health Care Services Following an Inpatient Hospital Stay Insurance Law and Public Health Law §§ 4903 permit issuers to require preauthorization for health care services other than emergency services. In order to permit hospitals to discharge insureds to lower levels of care when medically appropriate, the Department is directing issuers to suspend preauthorization requirements for in-network home health care services following an inpatient hospital admission for 60 days starting from the date of this letter. Issuers may review home health care services for medical necessity concurrently or retrospectively. Issuers subject to the Insurance Law for commercial coverage are also reminded that, pursuant to Insurance Law §§ 3216(i)(6), 3221(k)(1), and 4303(a)(3), the plan of care for home health care services must be established and approved in writing by a physician, and this requirement remains unchanged by this guidance, except to the extent that the state has permitted telehealth and verbal orders to suffice for this requirement for the duration of the COVID-19 declared state of emergency. VI. Suspension of Preauthorization for Inpatient Mental Health Services Issuers are reminded that Insurance Law §§ 3216(i)(30)(D), 3221(l)(6)(D), and 4303(k)(4) prohibit preauthorization and limit concurrent review for

inpatient substance use disorder treatment at in-network facilities certified by the Office of Addiction Services and Supports. Issuers are also reminded that, pursuant to Insurance Law §§ 3216(i)(35)(G), 3221(l)(5)(G), and 4303(g)(8), preauthorization is prohibited and concurrent review is limited for inpatient mental health treatment at in-network facilities licensed by the Office of Mental Health for insureds under the age of 18. See Insurance Circular Letter No. 13 (2019) for more information on these requirements. To the extent that preauthorization is required for inpatient mental health treatment for insureds over the age of 18, issuers are directed to suspend preauthorization for inpatient mental health treatment following a hospital admission for 60 days starting from the date of this letter in order to permit hospitals to discharge insureds more quickly. Hospitals should use their best efforts to transfer insureds to in-network providers.

VII. Retrospective Medical Necessity Denials Prohibited for Emergency Department and Inpatient Hospital Services for COVID-19 Insurance Law § 4902(a)(13) and Public Health Law § 4902(1)(k) prohibit issuers from denying emergency department and inpatient hospital services as not medically necessary on retrospective review if a general hospital certified pursuant to Public Health Law Article 28 rendered the services to an insured to treat COVID-19 during a declared state of emergency. Issuers are reminded that they are prohibited from denying emergency department and inpatient hospital treatment provided during the declared state of emergency for diagnosed or suspected COVID-19 cases as not medically necessary on retrospective review.

VIII. Notification Requirements for Emergency Hospital Admissions Hospitals typically notify issuers that an insured has been admitted to a hospital through the emergency department. Insurance Law §§ 3217-b(j) and 4325(k) and Public Health Law § 4406-c(8) provide that an issuer may not deny payment to a hospital for a claim for medically necessary inpatient services resulting from an emergency admission provided by a general hospital solely on the basis that the general hospital did not timely notify such issuer that the services had been provided. An issuer and hospital may agree to other requirements for timely notification that medically necessary inpatient services resulting from an emergency admission have been provided and to reductions in payment for failure to provide timely notification, subject to certain limitations. In circumstances where hospitals and issuers have agreed to such notification requirements, hospitals should use their best efforts to continue to provide to issuers notifications of emergency hospital admissions, including information necessary for the issuer to assist in coordinating care and discharge planning. Absent a contractual agreement to provide notification, hospitals are encouraged to use their best efforts to provide notifications to issuers of an emergency admission to assist in coordinating care and discharge planning. However, such notification requirements should not be overly burdensome, and issuers are directed to waive requirements for the submission of medical records as part of the notification for 60 days starting from the date of this letter. Issuers are encouraged to work with hospitals during the declared state of emergency for COVID-19 to ensure that care is coordinated to the extent practicable. Issuers should not impose a financial penalty on a hospital for a failure to provide notification of an emergency admission due to the need to implement the state's "surge and flex" protocol.

IX. Applicability to Third-Party Administrators of Self-Funded Plans Adherence to this circular letter is essential to ensure that hospitals are able to implement the state's "surge and flex" protocol in accordance with

the Governor's "Winter COVID-19 Plan." Third-party administrators, which are licensed by the Department as independent adjusters, are strongly encouraged to seek to apply the provisions of this circular letter to their administrative service arrangements with self-funded plans. X. Conclusion It is in the interest of all stakeholders that the state's "surge and flex" protocol is implemented in accordance with the Governor's "Winter COVID-19 Plan." Pursuant to the "surge and flex" protocol, hospitals must balance patient loads to ensure that they maintain capacity. In order to accomplish this objective, hospitals need flexibility in the admission and transfer of insureds. Issuers are directed to suspend the utilization review and notification requirements outlined in this circular letter so hospitals may quickly transfer or discharge insureds, as medically appropriate, to assist hospitals with the implementation of the state's "surge and flex" protocol. Please direct any questions regarding this circular letter by email to .

Very truly yours, Lisette Johnson Chief, Health Bureau Have a question or need help? Check our FAQs . If you still need help, contact DFS . Who We Supervise Institutions That We Supervise The Department of Financial Services supervises many different types of institutions. Supervision by DFS may entail chartering, licensing, registration requirements, examination, and more. Learn More Department of Financial Services About Us Mission and Leadership Advisory Boards Institutions That We Supervise Contact Us State Laws & Regulations State Codes, Rules & Regulations (NYCRR) State Laws (LBDC) State Bills & Laws (Senate) Website Accessibility & Reasonable Accommodations Disclaimer Privacy Policy Site Map Language Assistance Language Access Policies and Plans Department of Financial Services CONNECT WITH US