New York ACEP Member Guidance on the Implementation of New Out of Network (OON) Law (Chapter 60 of the Laws of 2014)

A new law regulating out-of-network health care services took effect March 31, 2015. Earlier this year, New York ACEP provided members with a comprehensive summary of the OON law and links to the New York State Department of Financial Services' (DFS) website. This summary of the law can be found on New York ACEP's website at www.nyacep.org under Government Affairs (Out of Network Regulations Effective March 31).

New York ACEP continues to receive questions from members concerning the new Independent Dispute Resolution (IDR) process and the impact of the law on billing and reimbursement practices. Provided below is additional information which addresses these questions.

Billing and Reimbursement

There is no prohibition in the law on balance billing a patient for emergency services. There is a prohibition on balance billing for a surprise bill received by a patient for non-emergency services when the patient has an assignment of benefits. The term "surprise bill," as defined in the law, does not include emergency services.

When a health plan receives a bill for emergency services from a non-participating provider, the plan is required to pay an amount that it determines reasonable, less applicable patient cost sharing. Either the health plan or the physician may file a payment dispute with the IDR entity.

The law places responsibility on the health plan to ensure that a patient receives no greater out-of-pocket costs than they would have incurred with a participating health care provider. New York ACEP encourages you to tell patients that they have the right to ask their insurance company to be held harmless.

There is no obligation for an insurance company to pay an out of network health care provider the full amount that is billed under the new law, nor was there such an obligation prior to passage of the OON law. As noted, the health care provider can bill the patient for the balance and the health plan is responsible for holding the patient harmless by either negotiating a different rate with the provider or paying the full amount. Patients with high deductible plans are responsible for paying the provider and the provider can bill the patient.

Independent Dispute Resolution Process

New York ACEP was successful in getting an exemption from the IDR process for particular emergency medicine CPT codes that are less than $600, after any applicable co payment, co-insurance, or deductible, that do not exceed 120% of Usual and Customary Cost (UCR). The $600 exemption will be applied by individual CPT code.

The $600 is subject to annual inflation adjustments. The current threshold for 2015, adjusted for inflation, is $613.50. Please note that the application of the patient cost sharing will increase the dollar amount that triggers an exemption from the IDR process. This exemption will include claims for evaluation, management, and most observation care provided by emergency physicians.

New York ACEP sought this exemption for high volume claims that are reimbursed at modest levels so that physicians would not be in a position of going to arbitration when the cost is higher than the potential benefit of winning an appeal against a health care plan. There was concern that this would provide an incentive for health plans to under reimburse physicians and that the physicians would not have the financial resources to go through the IDR process.

According to the Department of Financial Services (DFS), the cost of the IDR process will range from $225 to $325 per appeal.

UCR is defined as the 80th percentile of all charges for a health service rendered by a provider in the same or similar specialty and provided in the same geographic region as reported by a benchmarking database maintained by a nonprofit organization.

FAIR Health is currently the only entity recognized to calculate UCR. The following CPT codes that meet the exemption criteria: 99281, 99285, 99288, 99291, 99292, 99217, 99220, 99224,99226, and 99234, 99236.

If a health care provider finds a pattern by a health plan of reimbursing well below the usual and customary cost that information should be provided to DFS.

Patient Insurance Information

Patients sometimes do not have their insurance information available when they arrive at an emergency department. If a patient does not have their insurance information at the time of service, providers do not need to wait for insurance information to bill and should bill the patient immediately. A health plan is required to provide at least 120 days for timely filing, both out of and in network. The patient is responsible for the bill in the case of a non participating provider. In the case of participating providers, contracts may vary as to whether the patient is responsible for the bill. In addition, Section 3224-A (g) and (h) of the State Insurance Law allows for providers to ask for reconsideration of the 120 days under certain circumstances.

Patient Assignment of Benefits

Under the current law, a health plan is not required to honor a patient's assignment of benefits for emergency services.