



STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower

The Governor Nelson A. Rockefeller Empire State Plaza

Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 1, 2004

Sheila Humiston, Vice President
Public Policy & Regulatory Affairs
Health Plan Association
90 State Street, Suite 825
Albany, New York 12207

Cheryl Hogan, Counsel
New York State Conference of
Blue Cross and Blue Shield Plans
121 State Street
Albany, New York 12207

Dear Ms. Humiston and Ms. Hogan:

This is in response to your request for the Departments of Health and Insurance to review a list of codes that was believed appropriate for administrative denials on the grounds that such services were for cosmetic purposes in virtually every case. The list was reviewed by Foster Gesten, M.D. and peer reviewers at The Island Peer Review Organization (IPRO) to evaluate whether these services were likely always cosmetic in nature. After careful review and discussion, we believe the list includes codes for services where the issue of medical necessity could impact on whether the service is a covered benefit which would be provided to the member. As a result, we have modified the list to reflect those codes which we believe plans would be allowed to deny pursuant to the grievance process without conducting a clinical review. We believe all other codes listed on the previous list provided would be required to go through the utilization review process and undergo a clinical review before the managed care organization, Article 43 corporation or insurer (hereinafter "health plans") can deny the service.

Please note that our discussion of an acceptable procedure to deny under the grievance process based on procedure code presupposes that the claim or request for service was submitted without medical information. If a claim or request for one of the listed services is submitted with medical information, then the utilization review process (UR) must be followed to adjudicate that claim or request.

While we agree to allow health plans to deny specific requests for treatment, based on the codes reflected on the enclosed list, through the grievance process, members must be provided with information which would inform them of their right to a medical necessity review if

warranted. Therefore, health plans must include appropriate language in the notice to inform the member or provider that they may obtain a clinical review if the member or provider believes the request involves issues of medical necessity. Please provide examples of language that will be included with these denials to convey this requirement to members and providers. Also, if a health plan denies a requested service through the grievance process and the provider or member submits additional information that identifies issues of medical necessity, health plans must agree to allow the member to go through the UR process at the appeal level. We do not believe it is appropriate to require the member to start at the beginning of the UR process at this point, and would require the health plan to treat the request as an appeal under Article 49 of the PHL, which would require the issuance of a final adverse determination (FAD). This would allow the member to receive an External Review expeditiously.

We look forward to further discussing these issues with you in the near future. Feel free to contact us if you have any questions.

Sincerely,

Kathleen Shure
Director
Office of Managed Care

Thomas C. Zyra, JD
Co-chief, Health Bureau
New York Insurance Department

bcc: Ms. Lloyd
Dr. Gesten
Ms. Frescatore
Ms. Kozemko
Ms. Johnson