S T A T E O F N E W Y O R K

7071

I N S E N A T E

April 27, 2012

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the insurance law, in relation to utilization review and denial of claims

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subdivision 7 of section 4903 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

7. Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an [adverse determination subject to appeal pursuant to section forty nine hundred four of this title] APPROVAL.

S 2. Subsection (g) of section 4903 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(g) Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an [adverse determination subject to appeal pursuant to section four thousand nine hundred four of this title] APPROVAL.

S 3. Section 3224-a of the insurance law is amended by adding a new subsection (i) to read as follows:

(I)(1) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SUBSECTION (B) OF THIS SECTION, 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 NOT DENY PAYMENT FOR A CLAIM SUBMITTED BY A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW ON THE BASIS OF AN ADMINISTRATIVE OR TECHNICAL DEFECT, PROVIDED THAT AT LEAST NINETY PERCENT OF THE CLAIMS OTHERWISE SUBMITTED BY THE GENERAL HOSPITAL TO THAT INSURER OR ORGANIZATION OR CORPORATION IN THE PREVIOUS CALENDAR YEAR HAD NO ADMINISTRATIVE OR TECHNICAL DEFECT. FOR PURPOSES OF THIS SECTION, ADMINISTRATIVE OR TECHNICAL DEFECT MEANS FAILURE TO FOLLOW CONTRACTED PROCEDURES IN ACCESSING SERVICES, INCLUDING, BUT NOT LIMITED TO, FAILURE TO REQUEST APPROPRIATE OR NECESSARY AUTHORIZATION OF AN ADMISSION OR PROVISION OF SERVICES AND FAILURE TO PROVIDE PROPER NOTIFI-

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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CATION OF AN ADMISSION OR THE PROVISION OF SERVICES. THE INSURER OR ORGANIZATION OR CORPORATION SHALL LIMIT ITS REVIEW OF SUCH CLAIMS TO MEDICAL NECESSITY PURSUANT TO ARTICLE FORTY-NINE OF THIS CHAPTER OR ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW. IF THE CLAIM IS FOUND TO BE MEDICALLY NECESSARY, THE INSURER OR ORGANIZATION OR CORPORATION SHALL PROCESS THE CLAIM PURSUANT TO THIS SECTION. NOTHING IN THIS SUBSECTION SHALL BE DEEMED TO PRECLUDE A GENERAL HOSPITAL AND AN INSURER OR ORGANIZATION OR CORPORATION FROM AGREEING TO A PERCENTAGE LESS THAN NINETY PERCENT.

(2) FOR CLAIMS SUBMITTED BY A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW WITH AN ADMINISTRATIVE OR TECHNICAL DEFECT AND THAT ARE SUBJECT TO AN ADMINISTRATIVE OR TECHNICAL DENIAL, THE 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 PROVIDE WRITTEN NOTICE TO THE GENERAL HOSPITAL STATING THE GENERAL HOSPITAL HAD FAILED TO COMPLY WITH THE NINETY PERCENT STANDARD SET FORTH IN PARAGRAPH ONE OF THIS SUBSECTION IN THE PRIOR YEAR AND IS THEREFORE SUBJECT TO A DENIAL BASED ON AN ADMINISTRATIVE OR TECHNICAL DEFECT. THE NOTICE MUST ALSO IDENTIFY THE SPECIFIC ADMINISTRATIVE AND/OR TECHNICAL DEFECT THAT RESULTED IN THE CLAIM'S DENIAL.

S 4. Subsection (b) of section 3224-a of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(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.

IF THE SPECIFIC REASON PROVIDED IN ACCORDANCE WITH PARAGRAPH ONE OF THIS SUBSECTION FOR FAILURE TO PAY THE FULL CLAIM AS SUBMITTED IS THE ADJUSTMENT OF A PARTICULAR CODING TO A PATIENT INCLUDING THE ASSIGNMENT OF DIAGNOSIS AND PROCEDURE, THE HEALTH CARE PROVIDER MAY RESUBMIT THE AFFECTED CLAIM OR BILL FOR HEALTH CARE SERVICES WITH THE RELATED MEDICAL RECORD, WHICH MUST BE REVIEWED BY THE INSURER OR THE 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. Upon receipt of the information requested in paragraph two of this subsection, or THE MEDICAL RECORD 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. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW, ARTICLE FORTY-NINE OF THIS

CHAPTER, OR ANY OTHER PROVISION OF LAW, IF THE DISPUTED PORTION OF A CLAIM IS DENIED AFTER RESUBMISSION AND REVIEW OF THE MEDICAL RECORD PURSUANT TO THIS SUBSECTION DUE TO THE ADJUSTMENT OF A PARTICULAR CODING TO A PATIENT INCLUDING THE ASSIGNMENT OF DIAGNOSIS AND PROCEDURE, THE HEALTH CARE PROVIDER MAY SUBMIT AN EXTERNAL APPEAL TO BE PROCESSED IN ACCORDANCE WITH SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THE PUBLIC HEALTH LAW OR SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 5. Paragraph 1 of subsection (b) of section 4914 of the insurance law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(1) The insured shall have four months to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the insured have jointly agreed to waive any internal appeal, or after the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the insured's health care provider shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 6. Paragraph (a) of subdivision 2 of section 4914 of the public health law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(a) The enrollee shall have four months to initiate an external appeal after the enrollee receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal, or after the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the enrollee's health care provider shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the enrollee or the enrollee's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subdivision five of this section. The enrollee, and the enrollee's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the

applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 7. Subdivision 5 of section 4905 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

5. (A) If a health care service has been specifically pre-authorized or approved for an enrollee by a utilization review agent, a utilization review agent shall not, pursuant to retrospective review, revise or modify the specific standards, criteria or procedures used for the utilization review for procedures, treatment and services delivered to the enrollee during the same course of treatment.

(B) WHENEVER A UTILIZATION REVIEW AGENT MAKES A VERBAL REPRESENTATION REGARDING PREAUTHORIZATION OR APPROVAL, THE UTILIZATION REVIEW AGENT SHALL IMMEDIATELY, BUT NO LATER THAN, WITHIN ONE BUSINESS DAY SUPPLY THE PROVIDER WITH A WRITTEN CONFIRMATION OF THE APPROVAL BY EITHER:

(I) SENDING A COPY OF SUCH APPROVAL THROUGH ELECTRONIC MAIL TO AN ADDRESS SPECIFIED BY THE PROVIDER;

(II) SENDING A COPY OF SUCH APPROVAL THROUGH FACSIMILE TRANSMISSION TO A NUMBER SPECIFIED BY THE PROVIDER; OR

(III) POSTING A COPY OF SUCH APPROVAL ON A SPECIFIC WEBPAGE OF THE INSURER'S WEBSITE TO WHICH THE PROVIDER HAS BEEN DIRECTED AND TO WHICH THE PROVIDER HAS BEEN GIVEN ACCESS SO THAT THE PROVIDER MAY IMMEDIATELY PRINT AND RETAIN A HARD COPY.

S 8. Subsection (e) of section 4905 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(e) (1) If a health care service has been specifically preauthorized or approved for an insured by a utilization review agent, a utilization review agent shall not pursuant to retrospective review revise or modify the specific standards, criteria or procedures used for the utilization review for procedures, treatment and services delivered to the insured, during the same course of treatment.

(2) WHENEVER A UTILIZATION REVIEW AGENT MAKES A VERBAL REPRESENTATION REGARDING PREAUTHORIZATION OR APPROVAL, THE UTILIZATION REVIEW AGENT SHALL IMMEDIATELY, BUT NO LATER THAN, WITHIN ONE BUSINESS DAY SUPPLY THE PROVIDER WITH A WRITTEN CONFIRMATION OF THE APPROVAL BY EITHER:

(A) SENDING A COPY OF SUCH APPROVAL THROUGH ELECTRONIC MAIL TO AN ADDRESS SPECIFIED BY THE PROVIDER;

(B) SENDING A COPY OF SUCH APPROVAL THROUGH FACSIMILE TRANSMISSION TO A NUMBER SPECIFIED BY THE PROVIDER; OR

(C) POSTING A COPY OF SUCH APPROVAL ON A SPECIFIC WEBPAGE OF THE INSURER'S WEBSITE TO WHICH THE PROVIDER HAS BEEN DIRECTED AND TO WHICH THE PROVIDER HAS BEEN GIVEN ACCESS SO THAT THE PROVIDER MAY IMMEDIATELY PRINT AND RETAIN A HARD COPY.

S 9. Paragraph (h) of subdivision 1 of section 4902 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(h) Establishment of a requirement that emergency services rendered to an enrollee shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition. IN REVIEWING WHETHER EMERGENCY SERVICES ARE MEDICALLY NECESSARY TO STABILIZE OR TREAT AN EMERGENCY

CONDITION, THE UTILIZATION REVIEW AGENT SHALL TAKE THE FOLLOWING FACTORS INTO CONSIDERATION:

(I) THE TIME OF DAY AND DAY OF THE WEEK THE CARE WAS PROVIDED;

(II) THE PRESENTING SYMPTOMS, INCLUDING BUT NOT LIMITED TO, SEVERE PAIN, TO ENSURE THAT THE DECISION TO DENY REIMBURSEMENT FOR EMERGENCY SERVICE IS NOT MADE SOLELY ON THE BASIS OF THE FINAL DIAGNOSIS.

S 10. Paragraph 8 of subsection (a) of section 4902 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(8) Establishment of a requirement that emergency services rendered to an insured shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition. IN REVIEWING WHETHER EMERGENCY SERVICES ARE MEDICALLY NECESSARY TO STABILIZE OR TREAT AN EMERGENCY CONDITION, THE UTILIZATION REVIEW AGENT SHALL TAKE THE FOLLOWING FACTORS INTO CONSIDERATION:

(A) THE TIME OF DAY AND DAY OF THE WEEK THE CARE WAS PROVIDED;

(B) THE PRESENTING SYMPTOMS, INCLUDING BUT NOT LIMITED TO, SEVERE PAIN, TO ENSURE THAT THE DECISION TO DENY REIMBURSEMENT FOR EMERGENCY SERVICE IS NOT MADE SOLELY ON THE BASIS OF THE FINAL DIAGNOSIS.

S 11. This act shall take effect July 1, 2013; provided, however, that section three of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on and after such effective date.