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

7071--A

I N S E N A T E

April 27, 2012

Introduced by Sens. HANNON, LARKIN -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- reported favorably from said committee and committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to denial of claims

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

Section 1. 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 FOR A MEDICALLY NECESSARY SERVICE PROVIDED BY A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW ON THE BASIS OF AN 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 NOTIFICATION OF AN ADMISSION OR THE PROVISION OF SERVICES.

(2) NOTHING IN THIS SUBSECTION SHALL PRECLUDE A GENERAL HOSPITAL AND 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, FROM AGREEING TO REDUCTIONS IN PAYMENT FOR ADMINISTRATIVE OR TECHNICAL DEFECTS; PROVIDED, HOWEVER, THAT: (I) NO REDUCTION SHALL BE IMPOSED IF AT LEAST NINETY PERCENT OF THE CLAIMS OTHERWISE SUBMITTED BY THE GENERAL HOSPITAL TO THAT INSURER, ORGANIZATION OR CORPORATION IN THE PREVIOUS CALENDAR YEAR HAD NO ADMINISTRATIVE OR TECHNICAL DEFECT, (II) NO REDUCTION SHALL BE IMPOSED IF THE SERVICE WAS PREAUTHORIZED BY SUCH INSURER, ORGANIZATION OR CORPORATION, OR IF THE PATIENT'S INSURANCE COVERAGE WAS NOT KNOWN TO THE GENERAL

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

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HOSPITAL AT THE TIME THE SERVICE WAS PROVIDED, AND (III) ANY AGREED TO REDUCTIONS IN PAYMENT SHALL NOT EXCEED TWELVE PERCENT OF THE PAYMENT OTHERWISE DUE FROM SUCH INSURER, ORGANIZATION OR CORPORATION. FURTHERMORE, NOTHING IN THIS SUBSECTION SHALL BE DEEMED TO PRECLUDE A GENERAL HOSPITAL AND AN INSURER, ORGANIZATION OR CORPORATION FROM AGREEING TO NO REDUCTIONS IN PAYMENT FOR ADMINISTRATIVE OR TECHNICAL DEFECTS, OR TO REDUCTIONS OF LESS THAN TWELVE PERCENT.

S 2. 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, TO DETERMINE IF IT SUPPORTS THE CODING ASSIGNED BY THE HEALTH CARE PROVIDER. THE 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 PROCESS THE RESUBMITTED CLAIM BASED ON THE CODING SUPPORTED BY THE RELATED MEDICAL RECORD AND IN SO DOING SHALL COMPLY WITH SUBSECTION (A) OF THIS SECTION. 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.

S 3. This act shall take effect July 1, 2013; provided, however, that section one of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on and after such effective date.