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

7071--B

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 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health 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 3217-b of the insurance law is amended by adding a new subsection (j) to read as follows:

(J) (1) AN INSURER SHALL NOT DENY PAYMENT TO A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW 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 INSURER THAT THE SERVICES HAD BEEN PROVIDED.

(2) NOTHING IN THIS SUBSECTION SHALL PRECLUDE A GENERAL HOSPITAL AND AN INSURER FROM AGREEING TO 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 TIMELY NOTIFY; PROVIDED, HOWEVER THAT: (I) ANY REQUIREMENT FOR TIMELY NOTIFICATION MUST PROVIDE FOR A REASONABLE EXTENSION OF TIMEFRAMES FOR NOTIFICATION FOR EMERGENCY SERVICES PROVIDED ON WEEKENDS OR FEDERAL HOLIDAYS, (II) ANY AGREED TO REDUCTION IN PAYMENT FOR FAILURE TO TIMELY NOTIFY SHALL NOT EXCEED THE LESSER OF TWO THOUSAND DOLLARS OR TWELVE PERCENT OF THE PAYMENT AMOUNT OTHERWISE DUE FOR THE SERVICES PROVIDED, AND (III) ANY AGREED TO REDUCTION IN PAYMENT FOR FAILURE TO TIMELY NOTIFY SHALL NOT BE IMPOSED IF THE PATIENT'S INSURANCE COVERAGE COULD NOT BE DETERMINED BY THE HOSPITAL AFTER REASONABLE EFFORTS AT THE TIME THE INPATIENT SERVICES WERE PROVIDED.

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

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S 2. Section 4325 of the insurance law is amended by adding a new subsection (k) to read as follows:

(K) (1) A CORPORATION ORGANIZED UNDER THIS ARTICLE SHALL NOT DENY PAYMENT TO A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW 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 INSURER THAT THE SERVICES HAD BEEN PROVIDED.

(2) NOTHING IN THIS SUBSECTION SHALL PRECLUDE A GENERAL HOSPITAL AND A CORPORATION FROM AGREEING TO 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 TIMELY NOTIFY; PROVIDED, HOWEVER THAT: (I) ANY REQUIREMENT FOR TIMELY NOTIFICATION MUST PROVIDE FOR A REASONABLE EXTENSION OF TIMEFRAMES FOR NOTIFICATION FOR EMERGENCY SERVICES PROVIDED ON WEEKENDS OR FEDERAL HOLIDAYS, (II) ANY AGREED TO REDUCTION IN PAYMENT FOR FAILURE TO TIMELY NOTIFY SHALL NOT EXCEED THE LESSER OF TWO THOUSAND DOLLARS OR TWELVE PERCENT OF THE PAYMENT AMOUNT OTHERWISE DUE FOR THE SERVICES PROVIDED, AND (III) ANY AGREED TO REDUCTION IN PAYMENT SHALL NOT BE IMPOSED IF THE PATIENT'S INSURANCE COVERAGE COULD NOT BE DETERMINED BY THE HOSPITAL AFTER REASONABLE EFFORTS AT THE TIME THE INPATIENT SERVICES WERE PROVIDED.

S 3. Section 4406-c of the public health law is amended by adding a new subdivision 8 to read as follows:

8. (A) A HEALTH CARE PLAN SHALL NOT DENY PAYMENT TO A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER 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 HEALTH CARE PLAN THAT THE SERVICES HAD BEEN PROVIDED.

(B) NOTHING IN THIS SUBDIVISION SHALL PRECLUDE A GENERAL HOSPITAL AND A HEALTH CARE PLAN FROM AGREEING TO 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 TIMELY NOTIFY; PROVIDED, HOWEVER THAT: (I) ANY REQUIREMENT FOR TIMELY NOTIFICATION MUST PROVIDE FOR A REASONABLE EXTENSION OF TIMEFRAMES FOR NOTIFICATION FOR EMERGENCY SERVICES PROVIDED ON WEEKENDS OR FEDERAL HOLIDAYS, (II) ANY AGREED TO REDUCTION IN PAYMENT FOR FAILURE TO TIMELY NOTIFY SHALL NOT EXCEED THE LESSER OF TWO THOUSAND DOLLARS OR TWELVE PERCENT OF THE PAYMENT AMOUNT OTHERWISE DUE FOR THE SERVICE PROVIDED, AND (III) ANY AGREED TO REDUCTION IN PAYMENT SHALL NOT BE IMPOSED IF THE PATIENT'S COVERAGE COULD NOT BE DETERMINED BY THE HOSPITAL AFTER REASONABLE EFFORTS AT THE TIME THE INPATIENT SERVICES WERE PROVIDED.

S 4. Section 3224-a of the insurance law is amended by adding a new subsection (i) to read as follows:

(I) EXCEPT WHERE THE PARTIES HAVE DEVELOPED A MUTUALLY AGREED UPON PROCESS FOR THE RECONCILIATION OF CODING DISPUTES THAT INCLUDES A REVIEW OF SUBMITTED MEDICAL RECORDS TO ASCERTAIN THE CORRECT CODING FOR PAYMENT, A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW SHALL, UPON RECEIPT OF PAYMENT OF A CLAIM FOR WHICH PAYMENT HAS BEEN ADJUSTED BASED ON A PARTICULAR CODING TO A PATIENT INCLUDING THE ASSIGNMENT OF DIAGNOSIS AND PROCEDURE, HAVE THE OPPORTUNITY TO SUBMIT THE AFFECTED CLAIM WITH MEDICAL RECORDS SUPPORTING THE HOSPITAL'S INITIAL CODING OF THE CLAIM WITHIN THIRTY DAYS OF RECEIPT OF PAYMENT. UPON RECEIPT OF SUCH MEDICAL RECORDS, 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 SHALL REVIEW SUCH INFORMATION TO ASCERTAIN THE CORRECT CODING FOR PAYMENT AND PROCESS THE CLAIM IN ACCORDANCE WITH THE TIME-FRAMES SET FORTH IN SUBSECTION (A) OF THIS SECTION. IN THE EVENT THE INSURER, ORGANIZATION, OR CORPORATION PROCESSES THE CLAIM CONSISTENT WITH ITS INITIAL DETERMINATION, SUCH DECISION SHALL BE ACCOMPANIED BY A STATEMENT OF THE INSURER, ORGANIZATION OR CORPORATION SETTING FORTH THE SPECIFIC REASONS WHY THE INITIAL ADJUSTMENT WAS APPROPRIATE. AN INSUR-ER, ORGANIZATION, OR CORPORATION THAT INCREASES THE PAYMENT BASED ON THE INFORMATION SUBMITTED BY THE GENERAL HOSPITAL, BUT FAILS TO DO SO IN ACCORDANCE WITH THE TIMEFRAMES SET FORTH IN SUBSECTION (A) OF THIS SECTION, SHALL PAY TO THE GENERAL HOSPITAL INTEREST ON THE AMOUNT OF SUCH INCREASE AT THE RATE SET BY THE COMMISSIONER OF TAXATION AND FINANCE FOR CORPORATE TAXES PURSUANT TO PARAGRAPH ONE OF SUBDIVISION (E) OF SECTION ONE THOUSAND NINETY-SIX OF THE TAX LAW, TO BE COMPUTED FROM THE END OF THE FORTY-FIVE DAY PERIOD AFTER RESUBMISSION OF THE ADDI-TIONAL MEDICAL RECORD INFORMATION. PROVIDED, HOWEVER, A FAILURE TO REMIT TIMELY PAYMENT SHALL NOT CONSTITUTE A VIOLATION OF THIS SECTION. NEITHER THE INITIAL OR SUBSEQUENT PROCESSING OF THE CLAIM BY THE INSURER, ORGAN-IZATION, OR CORPORATION SHALL BE DEEMED AN ADVERSE DETERMINATION AS DEFINED IN SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER IF BASED SOLELY ON A CODING DETERMINATION. NOTHING IN THIS SUBSECTION SHALL APPLY TO THOSE INSTANCES IN WHICH THE INSURER OR ORGANIZATION, OR CORPORATION HAS A REASONABLE SUSPICION OF FRAUD OR ABUSE.

S 5. This act shall take effect July 1, 2013.