

5834

2013-2014 Regular Sessions

I N S E N A T E

June 17, 2013

Introduced by Sens. HANNON, LARKIN -- read twice and ordered printed,
and when printed to be committed to the Committee on Rules

AN ACT to amend the public health law and the insurance law, in relation
to approvals by a utilization review agent

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

1 Section 1. Subdivision 2 of section 4903 of the public health law, as
2 added by chapter 705 of the laws of 1996, is amended to read as follows:
3 2. A utilization review agent shall make a utilization review determination
4 involving health care services which require pre-authorization
5 and provide notice of a determination to the enrollee or enrollee's
6 designee and the enrollee's health care provider by telephone and in
7 writing within three business days of receipt of the necessary information.
8 TO THE EXTENT PRACTICABLE, SUCH WRITTEN NOTIFICATION TO THE
9 ENROLLEE'S HEALTH CARE PROVIDER SHALL BE TRANSMITTED ELECTRONICALLY, IN
10 A MANNER AND IN A FORM AGREED UPON BY THE PARTIES.
11 S 2. Paragraph (a) of subdivision 2 of section 4914 of the public
12 health law, as amended by chapter 219 of the laws of 2011, is amended to
13 read as follows:
14 (a) The enrollee shall have four months to initiate an external appeal
15 after the enrollee receives notice from the health care plan, or such
16 plan's utilization review agent if applicable, of a final adverse determination
17 or denial or after both the plan and the enrollee have jointly
18 agreed to waive any internal appeal, or after the enrollee is deemed to
19 have exhausted or is not required to complete any internal appeal pursuant
20 to section 2719 of the Public Health Service Act, 42 U.S.C. S
21 300gg-19. Where applicable, the enrollee's health care provider shall
22 have [forty-five] SIXTY days to initiate an external appeal after the
23 enrollee or the enrollee's health care provider, as applicable, receives
24 notice from the health care plan, or such plan's utilization review
25 agent if applicable, of a final adverse determination or denial or after

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

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1 both the plan and the enrollee have jointly agreed to waive any internal
2 appeal. Such request shall be in writing in accordance with the
3 instructions and in such form prescribed by subdivision five of this
4 section. The enrollee, and the enrollee's health care provider where
5 applicable, shall have the opportunity to submit additional documenta-
6 tion with respect to such appeal to the external appeal agent within the
7 applicable time period above; provided however that when such documenta-
8 tion represents a material change from the documentation upon which the
9 utilization review agent based its adverse determination or upon which
10 the health plan based its denial, the health plan shall have three busi-
11 ness days to consider such documentation and amend or confirm such
12 adverse determination.

13 S 3. Subsection (b) of section 4903 of the insurance law, as added by
14 chapter 705 of the laws of 1996, is amended to read as follows:

15 (b) A utilization review agent shall make a utilization review deter-
16 mination involving health care services which require pre-authorization
17 and provide notice of a determination to the insured or insured's desig-
18 nee and the insured's health care provider by telephone and in writing
19 within three business days of receipt of the necessary information. TO
20 THE EXTENT PRACTICABLE, SUCH WRITTEN NOTIFICATION TO THE ENROLLEE'S
21 HEALTH CARE PROVIDER SHALL BE TRANSMITTED ELECTRONICALLY, IN A MANNER
22 AND IN A FORM AGREED UPON BY THE PARTIES.

23 S 4. Paragraph 1 of subsection (b) of section 4914 of the insurance
24 law, as amended by chapter 219 of the laws of 2011, is amended to read
25 as follows:

26 (1) The insured shall have four months to initiate an external appeal
27 after the insured receives notice from the health care plan, or such
28 plan's utilization review agent if applicable, of a final adverse deter-
29 mination or denial, or after both the plan and the insured have jointly
30 agreed to waive any internal appeal, or after the insured is deemed to
31 have exhausted or is not required to complete any internal appeal pursu-
32 ant to section 2719 of the Public Health Service Act, 42 U.S.C. S
33 300gg-19. Where applicable, the insured's health care provider shall
34 have [forty-five] SIXTY days to initiate an external appeal after the
35 insured or the insured's health care provider, as applicable, receives
36 notice from the health care plan, or such plan's utilization review
37 agent if applicable, of a final adverse determination or denial or after
38 both the plan and the insured have jointly agreed to waive any internal
39 appeal. Such request shall be in writing in accordance with the
40 instructions and in such form prescribed by subsection (e) of this
41 section. The insured, and the insured's health care provider where
42 applicable, shall have the opportunity to submit additional documenta-
43 tion with respect to such appeal to the external appeal agent within the
44 applicable time period above; provided however that when such documenta-
45 tion represents a material change from the documentation upon which the
46 utilization review agent based its adverse determination or upon which
47 the health plan based its denial, the health plan shall have three busi-
48 ness days to consider such documentation and amend or confirm such
49 adverse determination.

50 S 5. This act shall take effect July 1, 2014.