

5834

2013-2014 Regular Sessions

I N   S E N A T E

June 17, 2013

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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.