

STATE OF NEW YORK

6648

2025-2026 Regular Sessions

IN ASSEMBLY

March 6, 2025

Introduced by M. of A. HUNTER -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to utilization review determinations

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Paragraphs 4 and 5 of subsection (b) of section 3224-b of
2 the insurance law are renumbered paragraphs 6 and 7 and two new para-
3 graphs 4 and 5 are added to read as follows:

4 (4) In the absence of fraud, a retrospective review or audit of a
5 claim by or on behalf of a health plan shall not reverse or otherwise
6 alter a determination of medical necessity previously made by a utiliza-
7 tion review agent or external appeal agent pursuant to article forty-
8 nine of this chapter or article forty-nine of the public health law.

9 (5) In the absence of fraud, a review or audit of a claim by or on
10 behalf of a health plan shall not downgrade or bundle the coding of a
11 claim if it has the effect of reversing or altering a determination of
12 medical necessity, which includes a level of care determination made by
13 or on behalf of the health plan.

14 § 2. Section 4900 of the insurance law is amended by adding a new
15 subsection (d-6) to read as follows:

16 (d-6) "Mental health and substance use disorders" means a mental
17 health condition or substance use disorder that falls under any of the
18 diagnostic categories listed in the mental and behavioral disorders
19 chapter of the most recent edition of the World Health Organization's
20 International Statistical Classification of Diseases and Related Health
21 Problems, or that is listed in the most recent version of the American
22 Psychiatric Association's Diagnostic and Statistical Manual of Mental
23 Disorders. Changes in terminology, organization, or classification of
24 mental health and substance use disorders in future versions of the
25 American Psychiatric Association's Diagnostic and Statistical Manual of

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

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Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

§ 3. Paragraph 7 of subsection (g-5) of section 4900 of the insurance law, as amended by chapter 357 of the laws of 2010, is amended and a new paragraph 8 is added to read as follows:

(7) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services[-]; and

(8) peer-reviewed practice guidelines, criteria, or recommendations from non-profit clinical specialty associations that are generally recognized by clinicians practicing in the relevant clinical specialty.

§ 4. Subsections (g-6) and (g-6-a) of section 4900 of the insurance law are relettered subsections (g-6-a) and (g-6-b) and a new subsection (g-6) is added to read as follows:

(g-6) "Medically necessary" or "medical necessity" means a covered health care service or product that addresses the specific needs of the insured for the purposes of preventing, screening, diagnosing, managing, treating, or minimizing the progression of an illness, injury, condition or its symptoms, and that is:

(1) in accordance with medical and scientific evidence;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the insurer or the insured or for the convenience of the insured or the health care provider.

§ 5. Subsection (g-6-b) of section 4900 of the insurance law, as added by section 11 of part H of chapter 60 of the laws of 2014, and as relettered by section 4 of this act, is amended to read as follows:

(g-6-b) "Out-of-network referral denial" means a denial under a managed care product as defined in subsection (c) of section four thousand eight hundred one of this chapter of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network referral denial pursuant to subsection (a-2) of section four thousand nine hundred four of this article. An out-of-network referral denial under this subsection does not constitute an adverse determination as defined in this article. An out-of-network referral denial shall not be construed to include an out-of-network denial as defined in subsection [~~(g-6)~~] (g-6-a) of this section.

§ 6. Paragraphs 8, 9, 10, 11 and 12 of subsection (a) of section 4902 of the insurance law, paragraph 8 as added by chapter 705 of the laws of 1996, paragraph 9 as amended by section 37 and paragraph 12 as added by section 38 of subpart A of part BB of chapter 57 of the laws of 2019,

1 and paragraphs 10 and 11 as added by chapter 512 of the laws of 2016,
2 are amended to read as follows:

3 (8) Establishment of a requirement that emergency services, including
4 emergency services for mental health and substance use disorders
5 provided by mobile crisis response teams or crisis receiving or stabili-
6 zation centers, rendered to an insured shall not be subject to prior
7 authorization nor shall reimbursement for such services be denied on
8 retrospective review[~~;~~ ~~provided, however, that such services are~~
9 ~~medically necessary~~]. Notwithstanding the foregoing, payment for emer-
10 gency services may be denied only if a health plan reasonable determines
11 the emergency services were never performed to stabilize or treat an
12 emergency condition.

13 (9) When conducting utilization review for purposes of determining
14 health care coverage for substance use disorder treatment, a utilization
15 review agent shall utilize [~~an evidence-based and~~] a peer reviewed clin-
16 ical review tool that is appropriate to the age of the patient, fully
17 consistent with medical and scientific evidence, and publicly identifies
18 all authors, reviewers, and editors who participated in the development
19 and review of such tool. When conducting such utilization review for
20 treatment provided in this state, a utilization review agent shall
21 utilize an evidence-based and peer reviewed clinical tool designated by
22 the office of [~~alcoholism and substance abuse~~] addiction services and
23 supports that is consistent with the treatment service levels within the
24 office of [~~alcoholism and substance abuse~~] addiction services and
25 supports system. All approved tools shall have inter rater reliability
26 testing completed by December thirty-first, two thousand sixteen.

27 [~~10-~~] (10) When establishing a step therapy protocol, a utilization
28 review agent shall utilize recognized [~~evidence-based and~~] peer reviewed
29 clinical review criteria that [~~also~~] is fully consistent with medical
30 and scientific evidence and takes into account the needs of atypical
31 patient populations and diagnoses when establishing the clinical review
32 criteria. The criteria shall publicly identify all authors, reviewers,
33 and editors who participated in the development and review of the crite-
34 ria.

35 [~~11-~~] (11) When conducting utilization review for a step therapy
36 protocol override determination, a utilization review agent shall
37 utilize, in addition to any other requirements of this article, [~~recog-~~
38 ~~nized evidence-based and~~] peer reviewed clinical review criteria that is
39 appropriate for the insured and the insured's medical condition and is
40 fully consistent with medical and scientific evidence. The criteria
41 shall publicly identify all authors, reviewers, and editors who partic-
42 ipated in the development and review of the criteria.

43 (12) When conducting utilization review for purposes of determining
44 health care coverage for a mental health condition, a utilization review
45 agent shall utilize [~~evidence-based and~~] peer reviewed clinical review
46 criteria that is fully consistent with medical and scientific evidence
47 and appropriate to the age of the patient. The utilization review agent
48 shall use clinical review criteria designated by the commissioner of the
49 office of mental health for level of care determinations, in consulta-
50 tion with the superintendent and the commissioner of health. For cover-
51 age determinations outside the scope of the criteria designated for
52 level of care determinations, the utilization review agent shall use
53 clinical review criteria deemed appropriate and approved for such use by
54 the commissioner of the office of mental health, in consultation with
55 the commissioner of health and the superintendent. Approved clinical

1 review criteria shall have inter rater reliability testing completed [~~by~~
2 ~~December thirty first, two thousand nineteen~~ prior to implementation.

3 § 7. Section 4903 of the insurance law is amended by adding a new
4 subsection (j) to read as follows:

5 (j) A utilization review agent shall authorize a request for a covered
6 health care service or product that is medically necessary.

7 § 8. Paragraphs (h), (i) and (j) of subdivision 1 and subdivisions 3
8 and 4 of section 4902 of the public health law, paragraph (h) of subdivi-
9 sion 1 as added by chapter 705 of the laws of 1996, paragraph (i) of
10 subdivision 1 as amended and paragraph (j) of subdivision 1 as added by
11 section 43 of subpart A of part BB of chapter 57 of the laws of 2019,
12 and subdivisions 3 and 4 as added by chapter 512 of the laws of 2016,
13 are amended to read as follows:

14 (h) Establishment of a requirement that emergency services, including
15 emergency services for mental health and substance use disorders
16 provided by mobile crisis response teams or crisis receiving or stabili-
17 zation centers, rendered to an enrollee shall not be subject to prior
18 authorization nor shall reimbursement for such services be denied on
19 retrospective review[~~;~~ ~~provided, however, that such services are~~
20 ~~medically necessary~~]. Notwithstanding the foregoing, payment for emer-
21 gency services may be denied only if a health plan reasonably determines
22 the emergency services were never performed to stabilize or treat an
23 emergency condition.

24 (i) When conducting utilization review for purposes of determining
25 health care coverage for substance use disorder treatment, a utilization
26 review agent shall utilize [~~an evidence-based and~~] a peer reviewed clin-
27 ical review tool that is appropriate to the age of the patient, fully
28 consistent with medical and scientific evidence, and publicly identifies
29 all authors, peer reviewers, and editors who participated in the devel-
30 opment and review of such tool. When conducting such utilization review
31 for treatment provided in this state, a utilization review agent shall
32 utilize an evidence-based and peer reviewed clinical tool designated by
33 the office of [~~alcoholism and substance abuse~~] addiction services and
34 supports that is consistent with the treatment service levels within the
35 office of [~~alcoholism and substance abuse~~] addiction services and
36 supports system. All approved tools shall have inter rater reliability
37 testing completed by December thirty-first, two thousand sixteen.

38 (j) When conducting utilization review for purposes of determining
39 health care coverage for a mental health condition, a utilization review
40 agent shall utilize [~~evidence-based and~~] peer reviewed clinical review
41 criteria that is fully consistent with medical and scientific evidence
42 and appropriate to the age of the patient. The utilization review agent
43 shall use clinical review criteria [~~deemed appropriate and approved for~~
44 ~~such use~~] designated by the commissioner of the office of mental health
45 for level of care determinations, in consultation with the commissioner
46 and the superintendent of financial services. For coverage determi-
47 nations outside the scope of the criteria designated for level of care
48 determinations, the utilization review agent shall use clinical review
49 criteria deemed appropriate and approved for such use by the commission-
50 er of the office of mental health, in consultation with the commissioner
51 and the superintendent of financial services. Approved clinical review
52 criteria shall have inter rater reliability testing completed [~~by Decem-~~
53 ~~ber thirty first, two thousand nineteen~~ prior to implementation.

54 3. When establishing a step therapy protocol, a utilization review
55 agent shall utilize [~~recognized evidence-based and~~] peer reviewed clin-
56 ical review criteria that is fully consistent with medical and scientif-

1 ic evidence and takes into account the needs of atypical patient popu-
2 lations and diagnoses [~~as well~~] when establishing the clinical review
3 criteria. The criteria shall publicly identify all authors, reviewers,
4 and editors who participated in the development and review of the crite-
5 ria.

6 4. When conducting utilization review for a step therapy protocol
7 override determination, a utilization review agent shall utilize, in
8 addition to any other requirements of this article, [~~recognized~~
9 ~~evidence-based and~~] peer reviewed clinical review criteria that is
10 appropriate for the enrollee and the enrollee's medical condition and is
11 fully consistent with medical and scientific evidence. The criteria
12 shall publicly identify all authors, reviewers, and editors who partic-
13 ipated in the development and review of the criteria.

14 § 9. This act shall take effect immediately.