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

3909

2009-2010 Regular Sessions

I N S E N A T E

April 3, 2009

Introduced by Sen. DUANE -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the insurance law, in relation to clarifying the grounds for an external appeal based on medical necessity

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

Section 1. Legislative findings and intent. Where there is a sound medical and scientific basis for a health care service or procedure, a patient should not be denied access to that care.

This legislation provides, in the external appeal process, that, where a health care plan denies coverage on grounds of "medical necessity", the insured shall have the opportunity to demonstrate, through his or her health care professional, based on applicable medical and scientific evidence, the patient's medical record, and any other patient information, that the proposed health service or treatment is likely to be more beneficial than any standard treatment or treatments for the patient's condition or disease.

This legislation does not require a health care plan to cover any health care service or treatment that would not otherwise be a covered benefit for the insured.

S 2. Subparagraph (A) of paragraph (d) of subdivision 2 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(A) MEDICAL NECESSITY. For external appeals requested pursuant to paragraph (a) of subdivision two of section forty-nine hundred ten of this title, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the health care plan acted reasonably and with sound medical judgment and in the best interest of the patient. When the external appeal agent makes

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

LBD01102-01-9

its determination, it shall consider the clinical standards of the plan, the information provided concerning the patient, the attending [physician's] HEALTH CARE PROFESSIONAL'S recommendation, and applicable generally accepted practice guidelines developed by the federal government, national or professional [medical] societies, boards and associations. WHERE APPLICABLE, THE APPEAL SHALL BE GRANTED IF, AND TO THE EXTENT, THE EXTERNAL APPEAL AGENT DETERMINES, UPON REVIEW OF THE APPLICABLE MEDICAL AND SCIENTIFIC EVIDENCE, THE PATIENT'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE PROPOSED HEALTH SERVICE OR TREATMENT IS LIKELY TO BE MORE BENEFICIAL THAN ANY STANDARD TREATMENT OR TREATMENTS FOR THE PATIENT'S CONDITION OR DISEASE OR NO TREATMENT; IF THE SPECIFIC HEALTH SERVICE OR TREATMENT RECOMMENDED BY THE HEALTH CARE PROFESSIONAL WOULD NOT OTHERWISE BE EXCLUDED FROM COVERAGE UNDER THE POLICY ON GROUNDS OTHER THAN MEDICAL NECESSITY.

Provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers,

(ii) be accompanied by a notice of appeal determination which shall include the reasons for the determination; provided, however, that where the final adverse determination is upheld on appeal, the notice shall include the clinical rationale, if any, for such determination,

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the enrollee, and

(v) be admissible in any court proceeding.

S 3. Subparagraph (A) of paragraph 4 of subsection (b) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(A) MEDICAL NECESSITY. For external appeals requested pursuant to paragraph one of subsection (b) of section four thousand nine hundred ten of this title, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the health care plan acted reasonably and with sound medical judgment and in the best interest of the patient. When the external appeal agent makes its determination, it shall consider the clinical standards of the plan, the information provided concerning the patient, the attending [physician's] HEALTH CARE PROFESSIONAL'S recommendation, applicable and generally accepted practice guidelines developed by the federal government, national or professional [medical] societies, boards and associations. WHERE APPLICABLE, THE APPEAL SHALL BE GRANTED IF, AND TO THE EXTENT, THE EXTERNAL APPEAL AGENT DETERMINES, UPON REVIEW OF THE APPLICABLE MEDICAL AND SCIENTIFIC EVIDENCE, THE PATIENT'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE PROPOSED HEALTH SERVICE OR TREATMENT IS LIKELY TO BE MORE BENEFICIAL THAN ANY STANDARD TREATMENT OR TREATMENTS FOR THE PATIENT'S CONDITION OR DISEASE OR NO TREATMENT; IF THE SPECIFIC HEALTH SERVICE OR TREATMENT RECOMMENDED BY THE HEALTH CARE PROFESSIONAL WOULD NOT OTHERWISE BE EXCLUDED FROM COVERAGE UNDER THE POLICY ON GROUNDS OTHER THAN MEDICAL NECESSITY. Provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers,

(ii) be accompanied by a notice of appeal determination which shall include the reasons for the determination; provided, however, that where the final adverse determination is upheld on appeal, the notice shall include the clinical rationale, if any, for such determination,

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the insured, and

(v) be admissible in any court proceeding.

S 4. This act shall take effect on the one hundred eightieth day after it shall have become a law.