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

6286

2011-2012 Regular Sessions

I N A S S E M B L Y

March 11, 2011

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

AN ACT to amend the insurance law, in relation to comprehensive motor vehicle reparations

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

Section 1. Section 5102 of the insurance law is amended by adding a new subsection (n) to read as follows:

(N) "HEALTH SERVICE PROVIDER" MEANS ANY MEDICAL PROVIDER THAT SUBMITS A BILL FOR PAYMENT UNDER BENEFITS DEFINED AND PROVIDED BY THIS SECTION FOR ANY OF THE FOLLOWING:

(1) MEDICAL, HOSPITAL (INCLUDING SERVICES RENDERED IN COMPLIANCE WITH ARTICLE FORTY-ONE OF THE PUBLIC HEALTH LAW, WHETHER OR NOT SUCH SERVICES ARE RENDERED DIRECTLY BY A HOSPITAL), SURGICAL, NURSING, DENTAL, AMBULANCE, X-RAY, PRESCRIPTION DRUG AND PROSTHETIC SERVICES;

(2) PSYCHIATRIC, PHYSICAL THERAPY (PROVIDED THAT TREATMENT IS RENDERED PURSUANT TO A REFERRAL) AND OCCUPATIONAL THERAPY AND REHABILITATION;

(3) ANY NONMEDICAL REMEDIAL CARE AND TREATMENT RENDERED IN ACCORDANCE WITH A RELIGIOUS METHOD OF HEALING RECOGNIZED BY THE LAWS OF THIS STATE; AND

(4) ANY OTHER PROFESSIONAL HEALTH SERVICES.

S 2. Subsection (a) of section 5106 of the insurance law is amended by adding two new undesignated paragraphs to read as follows:

PAYMENT OF THE INTEREST PENALTY AND REASONABLE ATTORNEY FEES TO A CLAIMANT WHEN PAYMENT OF A CLAIM IS OVERDUE SHALL BE THE EXCLUSIVE REMEDY WHEN AN INSURER FAILS TO MAKE TIMELY PAYMENT. THE FAILURE OF AN INSURER TO MAKE TIMELY PAYMENT OR ISSUE A DENIAL WITHIN THIRTY DAYS AFTER PROOF OF CLAIM HAS BEEN SUBMITTED TO AN INSURER SHALL NOT PRECLUDE SUCH INSURER FROM ISSUING A DENIAL OR ASSERTING A DEFENSE AFTER THE THIRTY DAY PERIOD HAS ELAPSED.

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

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THE CLAIMANT HAS THE BURDEN OF PROOF TO SHOW THE EXPENSES UNDER PARAGRAPH ONE OF SUBSECTION (A) OF SECTION FIVE THOUSAND ONE HUNDRED TWO OF THIS ARTICLE WERE MEDICALLY NECESSARY AND IN ACCORDANCE WITH THE APPLICABLE FEE SCHEDULE. EVIDENCE OF MAILING A CLAIM FORM SHALL NOT BE SUFFICIENT TO MEET THIS BURDEN.

S 3. Subsection (b) of section 5106 of the insurance law, as amended by chapter 452 of the laws of 2005, is amended to read as follows:

(b) [Every insurer shall provide a claimant with the option of submitting any dispute] ALL DISPUTES involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section SHALL BE SUBMITTED to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent. Such simplified procedures shall include an expedited eligibility hearing option, when required, to designate the insurer for first party benefits pursuant to subsection (d) of this section. The expedited eligibility hearing option shall be a forum for eligibility disputes only, and shall not include the submission of any particular bill, payment or claim for any specific benefit for adjudication, nor shall it consider any other defense to payment.

S 4. The insurance law is amended by adding a new section 5110 to read as follows:

S 5110. ASSIGNMENT OF BENEFITS TO HEALTH SERVICE PROVIDERS. (A) A "COVERED PERSON" HAS THE RIGHT TO ASSIGN CLAIMS FOR MEDICAL EXPENSES UNDER THIS ARTICLE TO A "HEALTH SERVICE PROVIDER", AND SUCH ASSIGNMENT SHALL AFFORD THE HEALTH SERVICE PROVIDER AS THE ASSIGNEE, THE RIGHTS, PRIVILEGES, AND REMEDIES FOR PAYMENT TO WHICH A COVERED PERSON IS ENTITLED TO UNDER THIS ARTICLE. HOWEVER, SUCH ASSIGNMENT IS VALID ONLY WHERE COVERAGE AND COMPLIANCE WITH POLICY TERMS BY THE COVERED PERSON ARE NOT IN DISPUTE.

(B) THE COVERED PERSON SHALL HAVE THE SOLE RIGHT TO CONTEST ANY ISSUES INVOLVING COVERAGE OR COMPLIANCE WITH POLICY TERMS BY THE COVERED PERSON.

(C) THE HEALTH SERVICE PROVIDER SHALL HAVE A LIEN AGAINST ANY RECOVERY BY THE COVERED PERSON FOR SERVICES PROVIDED.

(D) THE HEALTH SERVICE PROVIDER SHALL NOT PURSUE PAYMENT FOR THE COST OF SERVICES ARISING OUT OF THE INJURIES THE COVERED PERSON SUSTAINED DUE TO A MOTOR VEHICLE ACCIDENT UNLESS THERE IS A DETERMINATION THAT COVERAGE DOES NOT EXIST.

S 5. Section 5109 of the insurance law, as added by chapter 423 of the laws of 2005, is amended to read as follows:

S 5109. Unauthorized providers of health services. (a) [The superintendent, in consultation with the commissioner of health and the commissioner of education, shall by regulation, promulgate standards and procedures for investigating and suspending or removing the authorization for providers of health services to demand or request payment for health services as specified in paragraph one of subsection (a) of section five thousand one hundred two of this article upon findings reached after investigation pursuant to this section. Such regulations shall ensure the same or greater due process provisions, including notice and opportunity to be heard, as those afforded physicians investigated under article two of the workers' compensation law and shall include provision for notice to all providers of health services of the provisions of this section and regulations promulgated thereunder at least ninety days in advance of the effective date of such regulations] AS USED IN THIS SECTION, "HEALTH SERVICES" MEANS SERVICES, SUPPLIES,

THERAPIES OR OTHER TREATMENTS SPECIFIED IN SUBPARAGRAPH (I), (II) OR (IV) OF PARAGRAPH ONE OF SUBSECTION (A) OF SECTION FIVE THOUSAND ONE HUNDRED TWO OF THIS ARTICLE.

(b) [The commissioner of health and the commissioner of education shall provide a list of the names of all providers of health services who the commissioner of health and the commissioner of education shall deem, after reasonable investigation, not authorized to demand or request any payment for medical services in connection with any claim under this article because such] THE SUPERINTENDENT MAY PROHIBIT A provider of health services FROM DEMANDING OR REQUESTING PAYMENT FOR HEALTH SERVICES RENDERED UNDER THIS ARTICLE, FOR A PERIOD NOT EXCEEDING THREE YEARS, IF THE SUPERINTENDENT DETERMINES, AFTER NOTICE AND A HEARING, THAT THE PROVIDER OF HEALTH SERVICES:

(1) has ADMITTED TO, OR been FOUND guilty of, professional [or other] misconduct [or incompetency], AS DEFINED IN THE EDUCATION LAW, in connection with [medical] HEALTH services rendered under this article; or

(2) [has exceeded the limits of his or her professional competence in rendering medical care under this article or has knowingly made a false statement or representation as to a material fact in any medical report made in connection with any claim under this article; or

(3)] solicited, or [has] employed another PERSON to solicit for [himself or herself] THE PROVIDER OF HEALTH SERVICES or [for] another PERSON OR ENTITY, professional treatment, examination or care of [an injured] A person in connection with any claim under this article; or

[(4)] (3) has refused to appear before, or [to] answer ANY QUESTION upon request of, the [commissioner of health, the] superintendent[,] or any duly authorized officer of [the] THIS state, [any legal question,] or REFUSED to produce any relevant information concerning [his or her] THE conduct OF THE PROVIDER OF HEALTH SERVICES in connection with [rendering medical] HEALTH services RENDERED under this article; or

[(5)] (4) has engaged in [patterns] A PATTERN of billing for [services which were not provided]:

(I) HEALTH SERVICES ALLEGED TO HAVE BEEN RENDERED UNDER THIS ARTICLE, WHEN THE HEALTH SERVICES WERE NOT RENDERED; OR

(II) UNNECESSARY HEALTH SERVICES; OR

(5) UTILIZED UNLICENSED PERSONS TO RENDER HEALTH SERVICES UNDER THIS ARTICLE, WHEN ONLY A PERSON LICENSED IN THIS STATE MAY RENDER THE HEALTH SERVICES; OR

(6) UTILIZED LICENSED PERSONS TO RENDER HEALTH SERVICES, WHEN RENDERING THE HEALTH SERVICES IS BEYOND THE AUTHORIZED SCOPE OF THE PERSON'S LICENSE; OR

(7) CEDED OWNERSHIP, OPERATION OR CONTROL OF A BUSINESS ENTITY AUTHORIZED TO PROVIDE PROFESSIONAL HEALTH SERVICES IN THIS STATE, INCLUDING BUT NOT LIMITED TO A PROFESSIONAL SERVICE CORPORATION, LIMITED LIABILITY COMPANY OR REGISTERED LIMITED LIABILITY PARTNERSHIP, TO A PERSON NOT LICENSED TO RENDER THE HEALTH SERVICES FOR WHICH THE ENTITY IS LEGALLY AUTHORIZED TO PROVIDE, EXCEPT WHERE THE UNLICENSED PERSON'S OWNERSHIP, OPERATION OR CONTROL IS OTHERWISE PERMITTED BY LAW; OR

(8) COMMITTED A FRAUDULENT INSURANCE ACT AS DEFINED IN SECTION 176.05 OF THE PENAL LAW; OR

(9) HAS BEEN CONVICTED OF A CRIME INVOLVING FRAUDULENT OR DISHONEST PRACTICES; OR

(10) VIOLATED ANY PROVISION OF THIS ARTICLE OR REGULATIONS PROMULGATED THEREUNDER.

(c) [Providers] A PROVIDER of health services shall [refrain from subsequently treating for remuneration, as a private patient, any person seeking medical treatment] NOT DEMAND OR REQUEST PAYMENT FOR HEALTH SERVICES under this article [if such provider pursuant to this section has been prohibited from demanding or requesting any payment for medical services under this article. An injured claimant so treated or examined may raise this as] THAT ARE RENDERED DURING THE TERM OF THE PROHIBITION ORDERED BY THE SUPERINTENDENT PURSUANT TO SUBSECTION (B) OF THIS SECTION. THE PROHIBITION ORDERED BY THE SUPERINTENDENT MAY BE a defense in any action by [such] THE provider OF HEALTH SERVICES for payment for [treatment rendered at any time after such provider has been prohibited from demanding or requesting payment for medical services in connection with any claim under this article] SUCH HEALTH SERVICES.

(d) The [commissioner of health and the commissioner of education] SUPERINTENDENT shall maintain [and regularly update] a database containing a list of providers of health services prohibited by this section from demanding or requesting any payment for health services [connected to a claim] RENDERED under this article and shall make [such] THE information available to the public [by means of a website and by a toll free number].

(e) THE SUPERINTENDENT MAY LEVY A CIVIL PENALTY NOT EXCEEDING FIFTY THOUSAND DOLLARS ON ANY PROVIDER OF HEALTH SERVICES THAT THE SUPERINTENDENT PROHIBITS FROM DEMANDING OR REQUESTING A PAYMENT FOR HEALTH SERVICES PURSUANT TO SUBSECTION (B) OF THIS SECTION. ANY CIVIL PENALTY IMPOSED FOR A FRAUDULENT INSURANCE ACT, AS DEFINED IN SECTION 176.05 OF THE PENAL LAW, SHALL BE LEVIED PURSUANT TO ARTICLE FOUR OF THIS CHAPTER.

(F) Nothing in this section shall be construed as limiting in any respect the powers and duties of the commissioner of health, commissioner of education [or], the superintendent, OR INSURER to investigate instances of misconduct by a [health care] provider [and, after a hearing and upon written notice to the provider, to temporarily prohibit a provider of health services under such investigation from demanding or requesting any payment for medical services under this article for up to ninety days from the date of such notice] OF HEALTH SERVICES AND TAKE APPROPRIATE ACTION PURSUANT TO ANY OTHER PROVISION OF LAW. A DETERMINATION OF THE SUPERINTENDENT PURSUANT TO SUBSECTION (B) OF THIS SECTION SHALL NOT BE BINDING UPON THE COMMISSIONER OF HEALTH OR THE COMMISSIONER OF EDUCATION IN A PROFESSIONAL DISCIPLINARY PROCEEDING RELATING TO THE SAME CONDUCT.

S 6. Section 5108 of the insurance law is amended to read as follows:

S 5108. Limit on charges by providers of health services. (a) The charges for services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge, AND SHALL BE SUBJECT TO THE TREATMENT GUIDELINES ESTABLISHED PURSUANT TO SUBSECTION (D) OF THIS SECTION. AT NO TIME SHALL AN INSURER PAY ANY CHARGE THAT EXCEEDS THE CHARGES PERMISSIBLE UNDER THE SCHEDULE PREPARED AND ESTABLISHED BY THE CHAIR OF THE WORKERS' COMPENSATION BOARD.

(b) The superintendent, after consulting with the chairman of the workers' compensation board and the commissioner of health, shall promulgate rules and regulations implementing and coordinating the

provisions of this article and the workers' compensation law with respect to charges for the professional health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board, INCLUDING, BUT NOT LIMITED, TO DURABLE MEDICAL EQUIPMENT OR SUPPLIES. ADDITIONALLY, THE SUPERINTENDENT, AFTER CONSULTATION WITH THE WORKERS' COMPENSATION BOARD AND THE COMMISSIONER OF HEALTH, SHALL PROMULGATE TREATMENT GUIDELINES WITH THE RESPECT OF TREATING COVERED PERSONS. CHARGES FOR SERVICES THAT ARE NOT SPECIFICALLY SCHEDULED BY THE SUPERINTENDENT OF INSURANCE OR THE CHAIRMAN OF THE WORKERS' COMPENSATION BOARD, OR ARE NOT COMPENSABLE CHARGES UNDER MEDICARE ARE NOT COMPENSABLE HEALTH SERVICE CHARGES UNDER SUBSECTION (A) OF SECTION FIVE THOUSAND ONE HUNDRED TWO OF THIS ARTICLE.

(c) No provider of health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article may demand or request any payment in addition to the charges authorized pursuant to this section. NO SUCH PROVIDER MAY BE REIMBURSED FOR ANY SERVICES UNLESS THE PROVIDER COMPLIES WITH SUBSECTION (D) OF THIS SECTION. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health provider within thirty days after such insurer has knowledge of such pattern.

(D) NOTWITHSTANDING ANY OTHER PROVISION OF THE STATUTE, RULE OR REGULATION TO THE CONTRARY, THE FOLLOWING SHALL APPLY FOR ALL INDIVIDUALS OR ENTITIES THAT PROVIDE, TREAT, OR CHARGE FOR SERVICES SPECIFIED IN PARAGRAPH ONE OF SUBSECTION (A) OF SECTION FIVE THOUSAND ONE HUNDRED TWO OF THIS ARTICLE:

(1) THE TREATING PROVIDER SHALL FOLLOW THE TREATMENT GUIDELINES ESTABLISHED BY THE SUPERINTENDENT;

(2) DEVIATIONS FROM THE TREATMENT GUIDELINES MAY BE PERMITTED UNDER THE FOLLOWING CONDITIONS:

(I) PRIOR WRITTEN OR ELECTRONIC REQUEST IS GIVEN TO THE INSURER PRIOR TO COMMENCING TREATMENT. THE REQUEST SHALL CONTAIN JUSTIFICATION FOR THE DEVIATION FROM THE TREATMENT GUIDELINES. THE BURDEN OF SHOWING THE NECESSITY OF THE DEVIATION REMAINS SOLELY ON THE TREATING PROVIDER. FAILURE TO PROVIDE THIS REQUEST SHALL RESULT IN A MAXIMUM REIMBURSEMENT OF FIFTY PERCENT OF THE TREATMENT GUIDELINES.

(II) THE INSURER SHALL NOT BE PRECLUDED FROM EVALUATING THE DEVIATION FOR PAYMENT DURING THE PENDENCY OF THE REVIEW, AND MAY UTILIZE PEER REVIEW FOR EVALUATION OF THE DEVIATION.

(III) ANY DISPUTES SHALL BE RESOLVED THROUGH A PANEL OF EXPERTS WHO HAVE BEEN TRAINED OR CERTIFIED IN THE TREATMENT GUIDELINES PURSUANT TO SUBSECTION (E) OF SECTION FIVE THOUSAND ONE HUNDRED SIX OF THIS ARTICLE.

(3) AN INSURER MAY SCHEDULE AN INDEPENDENT MEDICAL EXAMINATION AT ANY TIME DURING THE COURSE OF TREATMENT.

(4) SERVICES OR SUPPLIES NOT COVERED BY THE TREATMENT GUIDELINES OR THE WORKERS' COMPENSATION FEE SCHEDULE SHALL NOT BE COMPENSABLE.

S 7. Section 5106 of the insurance law is amended by adding a new subsection (e) to read as follows:

(E) EVERY INSURER SHALL PROVIDE THE TREATING PROVIDER WITH THE OPTION OF SUBMITTING A DISPUTE INVOLVING A REQUEST FOR DEVIATIONS FROM THE TREATMENT GUIDELINES UNDER SUBSECTION (D) OF SECTION FIVE THOUSAND ONE HUNDRED EIGHT OF THIS ARTICLE TO ARBITRATION PURSUANT TO SIMPLIFIED PROCEDURES PROMULGATED OR APPROVED BY THE SUPERINTENDENT. SUCH SIMPLI-

FIED PROCEDURES SHALL INCLUDE ARBITRATION THROUGH A PANEL OF EXPERTS WHO HAVE BEEN TRAINED OR CERTIFIED IN THE TREATMENT GUIDELINES.

S 8. Subsection (b) of section 3425 of the insurance law is amended by adding a new undesignated paragraph to read as follows:

NOTWITHSTANDING ANY RULE, LAW OR REGULATION TO THE CONTRARY, AN INSURER MAY RESCIND, OR RETROACTIVELY CANCEL TO THE INCEPTION OF THE POLICY, COVERAGE FOR PERSONAL INJURY PROTECTION UNDER ARTICLE FIFTY-ONE OF THIS CHAPTER WHERE THERE IS NONPAYMENT OF THE INITIAL PREMIUM OR INITIAL INSTALLMENT WITHIN THE FIRST SIXTY DAYS, OR WHERE IT IS DISCOVERED THAT THE PAYMENT PROCEEDS OR IDENTITY OF THE PURPORTED POLICYHOLDER WERE STOLEN. A PERSON WHO IS INJURED DURING THIS PERIOD MAY HAVE RECOURSE UNDER A PERSONAL POLICY OF INSURANCE OR TO THE MOTOR VEHICLE INDEMNIFICATION CORPORATION PROVIDED SUCH PERSON DID NOT PARTICIPATE IN ANY FRAUDULENT ACTIVITY, INCLUDING BUT NOT LIMITED TO, A STAGED OR INTENTIONALLY CAUSED ACCIDENT.

S 9. This act shall take effect immediately and shall apply to all actions and proceedings commenced on or after such date; and shall also apply to any action or proceeding which was commenced prior to such effective date where, as of such date, a trial of the issues has not yet commenced.