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

5256

2013-2014 Regular Sessions

I N S E N A T E

May 15, 2013

Introduced by Sen. HANNON -- 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 approvals by a utilization review agent

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

Section 1. Subdivision 7 of section 4903 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

7. Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an [adverse determination subject to appeal pursuant to section forty nine hundred four of this title] APPROVAL.

S 2. The opening paragraph of subdivision 5 of section 4905 of the public health law is designated paragraph (a) and a new paragraph (b) is added to read as follows:

(B) WHENEVER A UTILIZATION REVIEW AGENT MAKES A VERBAL REPRESENTATION REGARDING PREAUTHORIZATION OR APPROVAL, THE UTILIZATION REVIEW AGENT SHALL IMMEDIATELY, BUT NOT LATER THAN WITHIN ONE BUSINESS DAY; SUPPLY THE PROVIDER WITH A WRITTEN CONFIRMATION OF THE APPROVAL BY EITHER:

(I) SENDING A COPY OF SUCH APPROVAL THROUGH ELECTRONIC MAIL TO AN ADDRESS SPECIFIED BY THE PROVIDER;

(II) SENDING A COPY OF SUCH APPROVAL THROUGH FACSIMILE TRANSMISSION TO A NUMBER SPECIFIED BY THE PROVIDER; OR

(III) POSTING A COPY OF SUCH APPROVAL ON A SPECIFIC WEBPAGE OF THE INSURER'S WEBSITE TO WHICH THE PROVIDER HAS BEEN DIRECTED AND TO WHICH THE PROVIDER HAS BEEN GIVEN ACCESS SO THAT THE PROVIDER MAY IMMEDIATELY PRINT AND RETAIN A HARD COPY.

S 3. Paragraph (a) of subdivision 2 of section 4914 of the public health law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

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

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(a) The enrollee shall have four months to initiate an external appeal after the enrollee receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal, or after the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the enrollee's health care provider shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the enrollee or the enrollee's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subdivision five of this section. The enrollee, and the enrollee's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 4. Subsection (g) of section 4903 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(g) Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an [adverse determination subject to appeal pursuant to section four thousand nine hundred four of this title] APPROVAL.

S 5. The opening paragraph of subsection (e) of section 4905 of the insurance law is designated paragraph 1 and a new paragraph 2 is added to read as follows:

(2) WHENEVER A UTILIZATION REVIEW AGENT MAKES A VERBAL REPRESENTATION REGARDING PREAUTHORIZATION OR APPROVAL, THE UTILIZATION REVIEW AGENT SHALL IMMEDIATELY, BUT NO LATER THAN WITHIN ONE BUSINESS DAY, SUPPLY THE PROVIDER WITH A WRITTEN CONFIRMATION OF THE APPROVAL BY EITHER:

(I) SENDING A COPY OF SUCH APPROVAL THROUGH ELECTRONIC MAIL TO AN ADDRESS SPECIFIED BY THE PROVIDER;

(II) SENDING A COPY OF SUCH APPROVAL THROUGH FACSIMILE TRANSMISSION TO A NUMBER SPECIFIED BY THE PROVIDER; OR

(III) POSTING A COPY OF SUCH APPROVAL ON A SPECIFIC WEBPAGE OF THE INSURER'S WEBSITE TO WHICH THE PROVIDER HAS BEEN DIRECTED AND TO WHICH THE PROVIDER HAS BEEN GIVEN ACCESS SO THAT THE PROVIDER MAY IMMEDIATELY PRINT AND RETAIN A HARD COPY.

S 6. Paragraph 1 of subsection (b) of section 4914 of the insurance law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(1) The insured shall have four months to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the insured have jointly agreed to waive any internal appeal, or after the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the insured's health care provider shall

have [forty-five days] FOUR MONTHS to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 7. This act shall take effect July 1, 2014.