AN ACT to amend the public health law, in relation to payments from the New York state medical indemnity fund

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

Section 1. Section 2999-j of the public health law is amended by adding two new subdivisions 2-a and 7-a to read as follows:

2-A. A REQUEST FOR REVIEW OF A DENIAL OF A CLAIM OR A DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION FOR THE PAYMENT OR REIMBURSEMENT FROM THE FUND FOR QUALIFYING HEALTH CARE COSTS MUST BE MADE BY THE CLAIMANT NO LATER THAN SIXTY DAYS FROM RECEIPT OF THE DENIAL AND, AT A CLAIMANT'S OPTION, BY EITHER (A) MAKING APPLICATION TO THE COURT WHEREIN THE JUDGMENT WAS AWARDED OR THE CASE WAS SETTLED, OR (B) FOLLOWING THE PROCESS ESTABLISHED BY REGULATIONS OF THE COMMISSIONER FOR THE ADMINISTRATIVE REVIEW OF A DENIAL OF A CLAIM OR REQUEST FOR PRIOR AUTHORIZATION.

7-A. A REQUEST FOR A REVIEW OF A DETERMINATION BY THE FUND ADMINISTRATOR THAT THE RELEVANT PROVISIONS OF SUBDIVISION SIX OF THIS SECTION HAVE NOT BEEN MET AND/OR THAT THE PLAINTIFF OR CLAIMANT IS NOT A QUALIFIED PLAINTIFF MAY BE MADE BY ANY OF THE PARTIES, NO LATER THAN SIXTY DAYS FROM RECEIPT OF THE DENIAL, BY MAKING APPLICATION TO THE COURT WHEREIN THE JUDGMENT WAS AWARDED OR THE CASE WAS SETTLED.

Section 2. Subdivisions 2 and 4 of section 2999-j of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, are amended to read as follows:

2. The provision of qualifying health care costs to qualified plaintiffs shall not be subject to prior authorization, except as described by the commissioner in regulation; provided, however[, that]:

(A) such regulation shall not prevent qualified plaintiffs from receiving care or assistance that would, at a minimum, be authorized under the medicaid program; [and provided, further, that]

(B) if any prior authorization is required by such regulation, the regulation shall require that requests for prior authorization be processed within a reasonably prompt period of time and, SUBJECT TO THE PROVISIONS OF SUBDIVISION TWO-A OF THIS SECTION, shall identify a proc-

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

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1. 4. The amount of qualifying health care costs to be paid from the fund shall be calculated[: (a) with respect to services provided in private physician practices on the basis of one hundred percent of the usual and customary rates,] on the basis of one hundred percent of the usual and customary cost. For the purposes of this section, "usual and customary costs" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of financial services. If no such rates are available qualifying health care costs shall be calculated on the basis of no less than one hundred thirty percent of Medicaid or Medicare rates of reimbursement, whichever is higher. If no such rate exists, costs shall be reimbursed as defined by the commissioner in regulation; or (b) with respect to all other services, on the basis of Medicaid rates of reimbursement or, where no such rates are available, as defined by the commissioner in regulation.

2. 5. This act shall take effect on the forty-fifth day after it shall have become a law.