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

4922--A

Cal. No. 1062

2015-2016 Regular Sessions

I N S E N A T E

April 23, 2015

Introduced by Sens. HANNON, LARKIN, VALESKY -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- reported favorably from said committee, ordered to first and second report, ordered to a third reading, amended and ordered reprinted, retaining its place in the order of third reading

AN ACT to amend the public health law and the insurance law, in relation to expedited utilization review of court ordered mental health and/or substance use disorder services

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

Section 1. Subdivision 2 of section 4903 of the public health law, as amended by section 22 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

2. (A) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify; [(a)] (I) whether the services are considered in-network or out-of-network; [(b)] (II) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment or co-insurance; [(c)] (III) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and [(d)] (IV) as applicable, information explaining how an enrollee may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for

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

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out-of-network health care services and the usual and customary cost for out-of-network health care services.

(B) WITH REGARD TO INDIVIDUAL OR GROUP CONTRACTS AUTHORIZED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER, FOR UTILIZATION REVIEW DETERMINATIONS INVOLVING PROPOSED MENTAL HEALTH AND/OR SUBSTANCE USE DISORDER SERVICES WHERE THE ENROLLEE OR THE ENROLLEE'S DESIGNEE HAS, IN A FORMAT PRESCRIBED BY THE SUPERINTENDENT OF FINANCIAL SERVICES, CERTIFIED IN THE REQUEST THAT THE PROPOSED SERVICES ARE FOR AN INDIVIDUAL WHO WILL BE APPEARING, OR HAS APPEARED, BEFORE A COURT OF COMPETENT JURISDICTION AND MAY BE SUBJECT TO A COURT ORDER REQUIRING SUCH SERVICES, THE UTILIZATION REVIEW AGENT SHALL MAKE A DETERMINATION AND PROVIDE NOTICE OF SUCH DETERMINATION TO THE ENROLLEE OR THE ENROLLEE'S DESIGNEE BY TELEPHONE WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE REQUEST. WRITTEN NOTICE OF THE DETERMINATION TO THE ENROLLEE OR ENROLLEE'S DESIGNEE SHALL FOLLOW WITHIN THREE BUSINESS DAYS. WHERE FEASIBLE, SUCH TELEPHONIC AND WRITTEN NOTICE SHALL ALSO BE PROVIDED TO THE COURT.

S 2. Subdivision 2 of section 4904 of the public health law, as amended by chapter 41 of the laws of 2014, is amended to read as follows:

2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:

(a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section forty-nine hundred three of this [article] TITLE; or

(b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination[.]; OR

(C) POTENTIAL COURT-ORDERED MENTAL HEALTH AND/OR SUBSTANCE USE DISORDER SERVICES PURSUANT TO PARAGRAPH (B) OF SUBDIVISION TWO OF SECTION FORTY-NINE HUNDRED THREE OF THIS TITLE. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph (c) of subdivision [3] THREE of section [four thousand nine] FORTY-NINE hundred three of this [article] TITLE, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. Provided that the enrollee or the enrollee's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph (c) of subdivision [3] THREE of section [four thousand nine] FORTY-NINE hundred three of this [article] TITLE, a utilization review agent shall not deny on the basis of medical necessi-

ty or lack of prior authorization such substance use disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

S 3. Subsection (b) of section 4903 of the insurance law, as amended by section 12 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

(b) (1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify: [(1)] (I) whether the services are considered in-network or out-of-network; [(2)] (II) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; [(3)] (III) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and [(4)] (IV) as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

(2) WITH REGARD TO INDIVIDUAL OR GROUP CONTRACTS AUTHORIZED PURSUANT TO ARTICLE THIRTY-TWO, FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, FOR UTILIZATION AND REVIEW DETERMINATIONS INVOLVING PROPOSED MENTAL HEALTH AND/OR SUBSTANCE USE DISORDER SERVICES WHERE THE INSURED OR THE INSURED'S DESIGNEE HAS, IN A FORMAT PRESCRIBED BY THE SUPERINTENDENT, CERTIFIED IN THE REQUEST THAT THE PROPOSED SERVICES ARE FOR AN INDIVIDUAL WHO WILL BE APPEARING, OR HAS APPEARED, BEFORE A COURT OF COMPETENT JURISDICTION AND MAY BE SUBJECT TO A COURT ORDER REQUIRING SUCH SERVICES, THE UTILIZATION REVIEW AGENT SHALL MAKE A DETERMINATION AND PROVIDE NOTICE OF SUCH DETERMINATION TO THE INSURED OR THE INSURED'S DESIGNEE BY TELEPHONE WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE REQUEST. WRITTEN NOTICE OF THE DETERMINATION TO THE INSURED OR INSURED'S DESIGNEE SHALL FOLLOW WITHIN THREE BUSINESS DAYS. WHERE FEASIBLE, SUCH TELEPHONIC AND WRITTEN NOTICE SHALL ALSO BE PROVIDED TO THE COURT.

S 4. Subsection (b) of section 4904 of the insurance law, as amended by chapter 41 of the laws of 2014, is amended to read as follows:

(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this [article or] TITLE; (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination; OR (3) POTENTIAL COURT-ORDERED MENTAL HEALTH AND/OR SUBSTANCE USE DISORDER SERVICES PURSUANT TO PARAGRAPH TWO OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS TITLE. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information

from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this [article] TITLE, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. Provided that the insured or the insured's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this [article] TITLE, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance use disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

S 5. This act shall take effect April 1, 2016 and shall apply to policies issued, renewed, or modified on and after such date.