

STATE OF NEW YORK

6120

2017-2018 Regular Sessions

IN ASSEMBLY

February 23, 2017

Introduced by M. of A. McDONALD -- read once and referred to the Committee on Health

AN ACT to amend the social services law, in relation to preserving access to quality complex rehabilitation technology for patients with complex medical needs

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Short title. This act shall be known and may be cited as
2 the "complex needs patient act".

3 § 2. Legislative intent. It is the intent of the legislature to:

4 1. protect access for complex needs patients to quality complex reha-
5 bilitation technology;

6 2. establish and improve standards and safeguards relating to the
7 provision of complex rehabilitation technology; and

8 3. provide quality support for complex needs patients to stay in the
9 home or community setting, prevent institutionalization, and prevent
10 hospitalizations and other costly secondary complications.

11 § 3. The social services law is amended by adding a new section 367-j
12 to read as follows:

13 § 367-j. Complex needs patient act. 1. Definitions. As used in this
14 section:

15 (a) "Complex needs patient" means an individual with significant phys-
16 ical or functional impairment resulting from a medical condition or
17 disease including, but not limited to: spinal cord injury, traumatic
18 brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteo-
19 genesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis,
20 multiple sclerosis, demyelinating disease, myelopathy, myopathy,
21 progressive muscular atrophy, anterior horn cell disease, post-polio
22 syndrome, cerebellar degeneration, dystonia, huntington's disease,
23 spinocerebellar disease, and certain types of amputation, paralysis or
24 paresis.

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

LBD04523-02-7

1 (b) "Complex rehabilitation technology" means products classified as
2 durable medical equipment within the medicare program as of January
3 first, two thousand fifteen that are individually configured for indi-
4 viduals to meet their specific and unique medical, physical and func-
5 tional needs and capacities for basic and functional activities of daily
6 living. Such products include, but are not limited to: individually
7 configured manual and power wheelchairs and accessories, adaptive seat-
8 ing and positioning items and accessories, and other specialized equip-
9 ment such as standing frames and gait trainers and accessories.

10 (c) "Employee" means a person whose taxes are withheld by a qualified
11 complex rehabilitation technology supplier and reported to the internal
12 revenue service.

13 (d) "Healthcare common procedure coding system", or "HCPCS", means the
14 billing codes used by medicare and overseen by the federal centers for
15 medicare and medicaid services that are based on the current procedural
16 technology codes developed by the American medical association.

17 (e) "Individually configured" means a device with a combination of
18 sizes, features, adjustments or modifications that are configured or
19 designed by a qualified complex rehabilitation technology supplier for a
20 specific individual by measuring, fitting, programming, adjusting or
21 adapting the device so that the device is consistent with the individ-
22 ual's medical condition, physical and functional needs and capabilities,
23 body size, period of need and intended use as determined by an assess-
24 ment or evaluation by a qualified health care professional.

25 (f) "Mixed HCPCS codes" means Healthcare Common Procedure Coding
26 System codes that refer to a mix of complex rehabilitation technology
27 products and standard mobility and accessory products.

28 (g) "Pure HCPCS codes" means Healthcare Common Procedure Coding System
29 codes that refer exclusively to complex rehabilitation technology
30 products.

31 (h) "Qualified complex rehabilitation technology professional" means
32 an individual who is certified as an assistive technology professional
33 (ATP) by the Rehabilitation Engineering and Assistive Technology Society
34 of North America (RESNA).

35 (i) "Qualified complex rehabilitation technology supplier" means a
36 company or entity that:

37 (i) is accredited by a recognized accrediting organization;

38 (ii) is an enrolled medicare supplier and meets the supplier and qual-
39 ity standards established for durable medical equipment suppliers
40 including those for complex rehabilitation technology under the medicare
41 program;

42 (iii) has at least one employee who is a qualified complex rehabili-
43 tation technology professional available to analyze the needs and capac-
44 ities of complex needs patients in consultation with a qualified health
45 care professional and participate in the selection of appropriate
46 complex rehabilitation technology and provide training in the proper use
47 of the complex rehabilitation technology;

48 (iv) requires a qualified complex rehabilitation technology profes-
49 sional be physically present for the evaluation and determination of
50 appropriate complex rehabilitation technology for complex needs
51 patients;

52 (v) has the capability to provide service and repair by qualified
53 technicians for all complex rehabilitation technology it sells;

54 (vi) has at least one storefront location within New York state; and

1 (vii) provides written information regarding how to receive service
2 and repair of complex rehabilitation technology to the complex needs
3 patient prior to the ordering of such technology.

4 (j) "Qualified health care professional" means a health care profes-
5 sional licensed by the state education department who has no financial
6 relationship with a qualified complex rehabilitation technology suppli-
7 er, including but not limited to a physician, physical therapist, occu-
8 pational therapist, or other licensed health care professional who
9 performs specialty evaluations within the professional's scope of prac-
10 tice.

11 2. Reimbursement and billing procedures. (a) To the extent permissible
12 under federal law, the commissioner shall maintain specific reimburse-
13 ment and billing procedures within the state medicaid program for
14 complex rehabilitation technology products and services to ensure that
15 medicaid payments for such products and services permit adequate access
16 to complex needs patients and takes into account the significant
17 resources, infrastructure, and staff needed to meet their needs.

18 (b) Pursuant to paragraph (a) of this subdivision, the commissioner
19 shall, not later than October first, two thousand nineteen: (i) desig-
20 nate products and services included in mixed and pure HCPCS billing
21 codes as complex rehabilitation technology, and as deemed necessary and
22 appropriate by the commissioner, create new billing codes or code modi-
23 fiers for services and products covered for complex needs patients; (ii)
24 set minimum standards consistent with paragraph (i) of subdivision one
25 of this section in order for suppliers to be considered qualified
26 complex rehabilitation technology suppliers eligible for medicaid
27 reimbursement; (iii) exempt products or services billed under mixed or
28 pure HCPCS codes from inclusion in any bidding, selective contracting,
29 request for proposal, or similar initiative; (iv) require complex needs
30 patients receiving a complex rehabilitation manual wheelchair, power
31 wheelchair, or seating component to be evaluated by a qualified health
32 care professional and a qualified complex rehabilitation technology
33 professional to qualify for reimbursement (such evaluation shall be
34 exempt from any health care professional cap); and (v) make other chang-
35 es as needed to protect access to complex rehabilitation technology for
36 complex needs patients. The reimbursement rate paid to providers for
37 complex rehabilitation technology products and services by managed care
38 organizations pursuant to section forty-four hundred three-f of the
39 public health law and section three hundred sixty-four-j of this title
40 shall be determined by agreement between the provider and managed care
41 organization. The amount of any reimbursement rate increase resulting
42 from the implementation of this section shall be specifically identified
43 in the managed care organization's premiums and the commissioner shall
44 provide for the expeditious increase of such premiums to ensure the
45 actuarial soundness and adequacy of such premiums and to accurately
46 account for the cost of the amounts paid to providers pursuant to this
47 section. The commissioner, in his or her judgment, may establish a
48 minimum benchmark reimbursement rate for managed care organizations to
49 pay contracted providers pursuant to this section, provided such bench-
50 mark rate is specifically identified and included in the managed care
51 organizations premiums.

52 § 4. This act shall take effect on the first of January next succeed-
53 ing the date on which it shall have become a law, and shall apply to
54 contracts and policies issued, renewed, modified or amended on or after
55 such effective date.