STATE OF NEW YORK

3707

2025-2026 Regular Sessions

IN ASSEMBLY

January 30, 2025

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

AN ACT to amend the insurance law and the public health law, in relation to downcoding on initial review and audits reversing or altering medical necessity determinations

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

Section 1. Paragraphs 4 and 5 of subsection (b) of section 3224-b of the insurance law are renumbered paragraphs 6 and 7 and two new paragraphs 4 and 5 are added to read as follows:

(4) A review or audit of claims by or on behalf of a health plan shall not reverse or otherwise alter a medical necessity determination, which includes a site of service or level of care determination made by a utilization review agent or external appeal agent pursuant to article forty-nine of this chapter or article forty-nine of the public health law.

(5) A review or audit of claims by or on behalf of a health plan shall not downgrade the coding of a claim if it has the effect of reversing or altering a medical necessity determination, which includes a site of service or level of care determination made by or on behalf of the health plan; provided however, that nothing in this paragraph shall limit a health plan's ability to review or audit claims for fraud, waste or abuse.

§ 2. Subsection (i) of section 3224-a of the insurance law, as amended by section 10 of part YY of chapter 56 of the laws of 2020, is amended to read as follows:

(i) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for payment, a general hospital certified pursuant to article twenty-eight of the public health law shall, upon receipt of payment of a claim for

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

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which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty days of receipt of payment. Upon receipt of such medical records, an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall review such information to ascertain the correct coding for payment based on national coding guidelines accepted by the centers for Medicare and Medicaid services or the American medical association, to the extent there are codes for such services, including ICD-10 guidelines to the extent available, and process the claim, including the correct coding, in accordance with the timeframes set forth in subsection (a) of this section. In the event the insurer, organization, or corporation processes the claim consistent with its initial determination, such decision shall be accompanied by a statement of the insurer, organization or corporation setting forth the specific reasons why the initial adjustment was appropriate. An insurer, organization, or corporation that increases the payment based on the information submitted by the general hospital, shall pay to the general hospital interest on the amount of such increase at the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law, to be computed from the date thirty days after initial receipt of the claim if transmitted electronically or forty-five days after initial receipt of the claim if transmitted by paper or facsimile. Provided, however, a failure to remit timely payment shall not constitute a violation of this section. [~~Neither the initial or subsequent processing of the claim by the insurer, organization, or corporation shall be deemed an adverse determination as defined in section four thousand nine hundred of this chapter if based solely on a coding determination.~~] Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse or when an insurer, organization, or corporation engages in reasonable fraud, waste and abuse detection efforts; provided, however, to the extent any subsequent payment adjustments are made as a result of the fraud, waste and abuse detection processes or efforts, such payment adjustments shall be consistent on the coding guidelines required by this subsection.

§ 3. Subsection (a) of section 4900 of the insurance law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

(a) "Adverse determination" means a determination by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary**, or a decision to downgrade the coding of a claim to a lower-level service than the one submitted by the provider for reimbursement**.

§ 4. Subdivision 1 of section 4900 of the public health law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

1. "Adverse determination" means a determination by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary**, or a decision to downgrade the coding of a claim to a lower-level service than the one submitted by the provider for reimbursement**.

§ 5. This act shall take effect immediately.