

# STATE OF NEW YORK

8590

2025-2026 Regular Sessions

## IN SENATE

November 26, 2025

Introduced by Sen. FAHY -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the insurance law, in relation to establishing timeframes for the payment of claims to hospitals

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

1 Section 1. Subsection (a) of section 3224-a of the insurance law is  
2 amended by adding 7 new paragraphs 1, 2, 3, 4, 5, 6 and 7 to read as  
3 follows:

4 (1) An insurer or an organization or corporation licensed or certified  
5 pursuant to article forty-three or forty-seven of this chapter or arti-  
6 cle forty-four of the public health law shall pay the claim to the  
7 hospital, as defined in article twenty-eight of the public health law,  
8 at the contracted rate for the services and site of service as billed  
9 within the timeframes set forth in this subsection. Such payment shall  
10 be made regardless of any such payor's medical necessity, payment or  
11 administrative policies, including, but not limited to, those policies  
12 regarding preauthorization, concurrent and retrospective medical neces-  
13 sity review, timely filing, and documentation requirements.

14 (2) Subsequent to and contingent upon paying the claim as billed, the  
15 payor may, within ninety days, request that the hospital submit the  
16 specific clinical documentation available to the treating physician at  
17 the time the determination was made that hospital care was clinically  
18 appropriate to a joint committee composed of equal numbers of medical  
19 directors and/or delegated clinicians from the payor and the hospital  
20 (the "joint committee") for a post payment review. The payor may only  
21 request submission of such documentation when there is a good faith,  
22 reasonable basis supported by specific information available for review  
23 by the joint committee that the service rendered by the hospital was not  
24 clinically appropriate. The payor shall not request documentation for  
25 more than ten percent of the claims paid since the last meeting of the

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

LBD11877-01-5

1 joint committee. If the joint committee finds that over fifty percent of  
2 the cases for which documentation was requested were billed inappropri-  
3 ately, the payor may prospectively increase the maximum percentage of  
4 paid claims for which documentation can be requested to fifteen percent.

5 (3) Within sixty business days of receiving a request for specific  
6 clinical documentation available to the treating physician at the time  
7 the determination was made that inpatient hospital care was clinically  
8 appropriate, the hospital shall provide the clinical documentation to  
9 the joint committee for a post payment review. The joint committee shall  
10 meet not less than quarterly to conduct such reviews. The payor shall  
11 not reduce, adjust, amend or change the billed claims except as set  
12 forth in paragraph five of this subsection.

13 (4) Failure by the hospital to provide the clinical documentation  
14 necessary to confirm the medical necessity of the hospital services to  
15 the joint committee within the sixty business days of request by the  
16 payor, as required by paragraph three of this subsection, shall result  
17 in an automatic appeal to the independent third-party review agent  
18 described in paragraph five of this subsection. Nothing herein shall  
19 require the joint committee to be registered as a utilization review  
20 agent under article forty-nine of the public health law or article  
21 forty-nine of this chapter.

22 (5) Upon receipt of the documentation requested pursuant to paragraph  
23 two of this subsection, but no later than the next regularly scheduled  
24 joint committee meeting, the joint committee shall review the documen-  
25 tation and make a joint determination, in accordance with policies and  
26 standards mutually agreed upon by the hospital and the payor, as to  
27 whether the hospital services were medically necessary based on the  
28 clinical information available to the treating provider at the time a  
29 patient was seen and/or admitted. The payor and hospital may agree to  
30 meet more frequently than quarterly so long as such frequency does not  
31 require the joint committee to meet more frequently than every thirty  
32 days. In the event a joint determination cannot be agreed upon by the  
33 end of the first joint committee meeting immediately following receipt  
34 of documentation requested pursuant to paragraph two of this  
35 subsection, the payor shall, in conjunction with the hospital, jointly  
36 forward the clinical documentation and any other information either  
37 party deems to be relevant and chooses to provide with regard to the  
38 determination of medical necessity to a mutually agreed upon independ-  
39 ent third-party review agent for a determination, which shall be bind-  
40 ing. If the independent review agent determines that the services  
41 provided were not medically necessary based on the clinical information  
42 available to the treating provider at the time a patient was seen  
43 and/or admitted, in accordance with those same standards considered by  
44 the joint committee, in whole or in part, the hospital shall refund the  
45 payor the amount determined to be not medically necessary within thirty  
46 days. If the joint committee or independent third-party review deter-  
47 mines that the services were not medically necessary, in whole or in  
48 part, the hospital shall not bill the insured, except for any applicable  
49 copayment, coinsurance or deductible that would be owed for the  
50 services.

51 (6) Nothing in this subsection shall preclude a payor and a health  
52 care provider from agreeing to other dispute resolution mechanisms  
53 provided that the payor remains responsible to pay the claim as billed  
54 by the hospital prior to reviewing such claim for medical necessity.  
55 Furthermore, when a hospital and payor are parties to a participating  
56 provider agreement applicable to the hospital services being reviewed by

1 the joint committee, the definition of medical necessity set forth in  
2 such participating provider agreement shall apply for purposes of joint  
3 committee and independent third party review; however, such definition  
4 of medical necessity shall not simply reference back to a payor's poli-  
5 cies, nor shall it include site of service or cost.

6 (7) Nothing in this subsection shall be construed as limiting or  
7 abridging in any way a health care provider's rights under paragraph  
8 nine of subsection (i) of section thirty-two hundred sixteen or para-  
9 graph eight of subsection (a) of section forty-nine hundred two of this  
10 chapter with respect to insurance coverage for services to treat an  
11 emergency condition.

12 § 2. This act shall take effect January 1, 2026. Effective immediate-  
13 ly, the addition, amendment and/or repeal of any rule or regulation  
14 necessary for the implementation of this act on its effective date are  
15 authorized to be made and completed on or before such effective date.