§ 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to this article and articles forty-two, forty-three and forty-seven of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or 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 adhere to the following standards:

(a) Except in a case where the obligation of 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 to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.

(b) In a case where the obligation of 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 to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder,

covered person or health care provider in writing, and through the internet or other electronic means for claims submitted in that manner, within thirty calendar days of the receipt of the claim:

(1) whether the claim or bill has been denied or partially approved;

(2) which claim or medical payment that it is not obligated to pay stating the specific reasons why it is not liable; and

(3) to request all additional information needed to determine liability to pay the claim or make the health care payment; and

(4) of the specific type of plan or product the policyholder or covered person is enrolled in; provided that nothing in this section shall authorize discrimination based on the source of payment.

Upon receipt of the information requested in paragraph three of this subsection or an appeal of a claim or bill for health care services denied pursuant to this subsection, an insurer or 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 comply with subsection (a) of this section; provided, that if the insurer or 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 determines that payment or additional payment is due on the claim, such payment shall be made to the policyholder or covered person or health care provider within fifteen days of the determination. Any denial or partial approval of claim or payment and the specific reasons for such denial or partial approval pursuant to this subsection shall be prominently displayed on a written notice with at least twelve-point type. A partial approval of claim or payment shall state at the top of such written notice with at least fourteen-point type bold: "NOTICE OF PARTIAL APPROVAL OF MEDICAL COVERAGE". A denial of claim or payment shall state at the top of such written notice with at least fourteen-point type bold: "NOTICE OF DENIAL OF MEDICAL COVERAGE". Any additional terms or conditions included on such notice of partial approval or such notice of denial, such as but not limited to time restraints to file an appeal, shall be included with at least twelve-point type.

(c) (1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this

section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to 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 or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

(2) Where a violation of this section is determined by the superintendent as a result of the superintendent's own investigation, examination, audit or inquiry, an insurer or 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 not be subject to a civil penalty prescribed in paragraph one of this subsection, if the superintendent determines that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section. This paragraph shall not apply to violations of this section determined by the superintendent resulting from individual complaints submitted to the superintendent by health care providers or policyholders.

(d) For the purposes of this section:

(1) "policyholder" shall mean a person covered under such policy or a representative designated by such person;

(2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen or

thirty-one of the mental hygiene law, a fiscal intermediary operating under section three hundred sixty-five of the social services law, a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical products, services or durable medical equipment, or a representative designated by such entity or person;

(3) "plan or product" shall mean:

(i) Medicaid coverage provided pursuant to section three hundred sixty-four-j of the social services law;

(ii) a child health insurance plan certified pursuant to section twenty-five hundred eleven of the public health law;

(iii) basic health program coverage certified pursuant to section three hundred sixty-nine-gg of the social services law, including the specific rating group the policyholder or covered person is enrolled in;

(iv) coverage purchased on the New York insurance exchange established pursuant to section two hundred sixty-eight-b of the public health law; and

(v) any other comprehensive health insurance coverage subject to article thirty-two, forty-three, or forty-seven of this chapter, or article forty-four of the public health law; and

(4) "emergency services" shall have the meaning set forth in subparagraph (D) of paragraph nine of subsection (i) of section three thousand two hundred sixteen of this article, subparagraph (D) of paragraph four of subsection (k) of section three thousand two hundred twenty-one of this article and subparagraph (D) of paragraph two of subsection (a) of section four thousand three hundred three of this chapter.

(e) Nothing in this section shall in any way be deemed to impair any right available to the state to adjust the timing of its payments for medical assistance pursuant to title eleven of article five of the social services law, or for child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law or otherwise be deemed to require adjustment of payments by the state for such medical assistance or child health insurance.

(f) In any action brought by the superintendent pursuant to this section or article twenty-four of this chapter relating to this section regarding payments for medical assistance pursuant to title eleven of

article five of the social services law, child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law, benefits under the voucher insurance program pursuant to section one thousand one hundred twenty-one of this chapter, and benefits under the New York state small business health insurance partnership program pursuant to article nine-A of the public health law, it shall be a mitigating factor that the insurer, corporation or organization is owed any premium amounts, premium adjustments, stop-loss recoveries or other payments from the state or one of its fiscal intermediaries under any such program.

(g) Time period for submission of claims. (1) Except as otherwise provided by law, health care claims must be initially submitted by health care providers within one hundred twenty days after the date of service to be valid and enforceable against an insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law. Provided, however, that nothing in this subsection shall preclude the parties from agreeing to a time period or other terms which are more favorable to the health care provider. Provided further that, in connection with contracts between organizations or corporations licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law and health care providers for the provision of services pursuant to section three hundred sixty-four-j or three hundred sixty-nine-ee of the social services law or title I-A of article twenty-five of the public health law, nothing herein shall be deemed: (i) to preclude the parties from agreeing to a different time period but in no event less than ninety days; or (ii) to supersede contract provisions in existence at the time this subsection takes effect except to the extent that such contracts impose a time period of less than ninety days.

(2) This subsection shall not abrogate any right or reduce or limit any additional time period for claim submission provided by law or regulation specifically applicable to coordination of benefits in effect prior to the effective date of this subsection.

(h) (1) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law shall permit a

participating health care provider to request reconsideration of a claim that is denied exclusively because it was untimely submitted pursuant to subsection (g) of this section. The insurer or organization or corporation shall pay such claim pursuant to the provisions of paragraph two of this subsection if the health care provider can demonstrate both that: (i) the health care provider's non-compliance was a result of an unusual occurrence; and (ii) the health care provider has a pattern or practice of timely submitting claims in compliance with subdivision (g) of this section.

(2) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law may reduce the reimbursement due to a health care provider for an untimely claim that otherwise meets the requirements of paragraph one of this subsection by an amount not to exceed twenty-five percent of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing in this subsection shall preclude a health care provider and an insurer or organization or corporation from agreeing to a lesser reduction. The provisions of this subsection shall not apply to any claim submitted three hundred sixty-five days after the date of service, in which case the insurer or organization or corporation may deny the claim in full.

(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 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.

(j) 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 or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter shall accept claims submitted by a policyholder or covered person, in writing, including through the internet, by electronic mail or by facsimile.

(k) The superintendent, in conjunction with the commissioner of

health, shall convene a health care administrative simplification workgroup. The workgroup shall consist of stakeholders, including but not limited to, insurers, hospitals, physicians and consumers or their representatives, to study and evaluate mechanisms to reduce health care administrative costs and complexities through standardization, simplification and technology. Areas to be examined by the workgroup shall include claims submission and payment, claims attachments, preauthorization practices, provider credentialing, insurance eligibility verification, and access to electronic medical records. The workgroup shall report on its findings and recommendations to the superintendent, the commissioner of health, the speaker of the assembly and the temporary president of the senate within eighteen months of the effective date of this subsection.

(l) Payments to nonparticipating or nonpreferred providers of ambulance services licensed under article thirty of the public health law. (1) Whenever 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 provides that any health care claims submitted under contracts or agreements issued or entered into pursuant to this article or article forty-two, forty-three or forty-seven of this chapter and article forty-four of the public health law are payable to a participating or preferred provider of ambulance services for services rendered, the insurer, 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 be required to pay such benefits either directly to any similarly licensed nonparticipating or nonpreferred provider at the usual and customary charge, which shall not be excessive or unreasonable, when the provider has rendered such services, has on file a duly executed assignment of benefits, and has caused notice of such assignment to be given to the insurer, 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 or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the insurer, 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 be required to send such benefit payments directly to the provider who has the assignment on file. When payment is made directly to a provider of ambulance services as authorized by this section, the insurer, 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 give written notice of such payment to the insured, subscriber, or other covered person.

(2) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be excessive or unreasonable.

(3) Nothing contained in this section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by participating or preferred providers and nonparticipating or nonpreferred providers.

The provisions of this section shall not apply to policies that do not include coverage for ambulance services.