**§ 3238. Pre-authorization of health care services.** (a) An insurer, corporation organized pursuant to article forty-three of this chapter, municipal cooperative health benefits plan certified pursuant to article forty-seven of this chapter, or health maintenance organization and other organizations certified pursuant to article forty-four of the public health law ("health plan") shall pay claims for a health care service for which a pre-authorization was required by, and received from, the health plan prior to the rendering of such health care service, unless:

(1) (i) the insured, subscriber, or enrollee was not a covered person at the time the health care service was rendered.

(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, a health plan shall not deny a claim on this basis if the insured's, subscriber's or enrollee's coverage was retroactively terminated more than one hundred twenty days after the date of the health care service, provided that the claim is submitted within ninety days after the date of the health care service. If the claim is submitted more than ninety days after the date of the health care service, the health plan shall have thirty days after the claim is received to deny the claim on the basis that the insured, subscriber or enrollee was not a covered person on the date of the health care service.

(2) the submission of the claim with respect to an insured, subscriber or enrollee was not timely under the terms of the applicable provider contract, if the claim is submitted by a provider, or the policy or contract, if the claim is submitted by the insured, subscriber or enrollee;

(3) at the time the pre-authorization was issued, the insured, subscriber or enrollee had not exhausted contract or policy benefit limitations based on information available to the health plan at such time, but subsequently exhausted contract or policy benefit limitations after authorization was issued; provided, however, that the health plan shall include in the notice of determination required pursuant to subsection (b) of section four thousand nine hundred three of this chapter and subdivision two of section forty-nine hundred three of the public health law that the visits authorized might exceed the limits of the contract or policy and accordingly would not be covered under the

contract or policy;

(4) the pre-authorization was based on materially inaccurate or incomplete information provided by the insured, subscriber or enrollee, the designee of the insured, subscriber or enrollee, or the health care provider such that if the correct or complete information had been provided, such pre-authorization would not have been granted;

(5) the pre-authorized service was related to a pre-existing condition that was excluded from coverage; or

(6) there is a reasonable basis supported by specific information available for review by the superintendent that the insured, subscriber or enrollee, the designee of the insured, subscriber or enrollee, or the health care provider has engaged in fraud or abuse.

(b) Nothing in this section shall be construed to prohibit a health plan from denying continued or extended coverage as part of a concurrent review of a health care service.

(c)(1) If a health care provider, while providing a service or procedure to treat a patient, determines that providing an additional or related service or procedure, such as a service or procedure to address a co-morbid condition, is immediately necessary as part of such treatment, and in the clinical judgment of the health care provider it is a medically timely service and it would not be medically advisable to interrupt the provision of care to the patient in order to obtain pre-authorization from a health plan for the additional or related service or procedure, a denial of payment for the additional or related service or procedure due to lack of pre-authorization shall be upheld on appeal only if it is determined that:

(i) the additional or related service or procedure is not a covered benefit;

(ii) the additional or related service or procedure was not medically necessary pursuant to section four thousand nine hundred four of this chapter or section forty-nine hundred four of the public health law;

(iii) the additional or related service or procedure was experimental or investigational pursuant to section four thousand nine hundred four of this chapter or section forty-nine hundred four of the public health law; or

(iv) one of the conditions set forth in paragraphs one through six of subsection (a) of this section is met.

(2) The provisions of this subsection shall apply to situations in which pre-authorization was required and received for the initial service or procedure.

(3) The provisions of this subsection shall apply without regard to whether the current procedural terminology (CPT) code for the additional or related service or procedure is different than the CPT code for the initial service or procedure.

(d) Payment for such health care services shall be subject to a health plan's provider contracts or claims payment policies that are consistent with applicable law, rule or regulation.

(e) Nothing in this section shall be deemed to limit the right of a health plan to deny a claim if the health plan determines that it is not primarily obligated to pay the claim because other insurance coverage exists that is primary, including but not limited to workers' compensation and no-fault coverage.

(f) Notification that a health care service is being provided shall not constitute a request for pre-authorization of that health care service for purposes of this section; provided, however, that if a health plan provides a written acknowledgement of the notification to the health care provider, such acknowledgment shall clearly state that the acknowledgment does not constitute a pre-authorization of the services to be rendered.

(g) Nothing in this section shall preclude a health care provider and a health plan from agreeing to provisions different from those in this section; provided, however, that any agreement that purports to waive, limit, disclaim, or in any way diminish the rights of a health care provider set forth in this section shall be void as contrary to public policy.