§ 4803. Health care professional applications and terminations. (a) (1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within sixty days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to: (A) whether he or she is credentialed; or (B) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

(2) If the completed application of a newly-licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this state, who joins a group practice of health care professionals each of whom participates in the in-network portion of an insurer's network, is neither approved nor declined within sixty days of submission of a completed application pursuant to paragraph one of this subsection, such health care professional shall be deemed "provisionally credentialed" and may participate in the in-network portion of an insurer's network; provided, however, that a provisionally credentialed physician may not be designated as an insured's primary care physician until such time as the physician has been fully credentialed. The network participation for a provisionally credentialed health care professional shall begin on the day following the sixtieth day of receipt of the completed application and shall last until the final credentialing determination is made by

the insurer. A health care professional shall only be eligible for provisional credentialing if the group practice of health care professionals notifies the insurer in writing that, should the application ultimately be denied, the health care professional or the group practice: (A) shall refund any payments made by the insurer for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the insured's contract with the insurer; and (B) shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of an insurer's network. Interest and penalties pursuant to section three thousand two hundred twenty-four-a of this chapter shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent an insurer from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim. An insurer shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

(3) A newly-licensed physician, a physician who has recently relocated to this state from another state and has not previously practiced in this state, or a physician who has changed his or her corporate relationship such that it results in the issuance of a new tax identification number under which such physician's services are billed for and who previously had a participation contract with the insurer immediately prior to the event that changed his or her corporate relationship, who becomes employed by a general hospital or diagnostic and treatment center licensed pursuant to article twenty-eight of the public health law, or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law which has a participating provider contract with an insurer, and whose other employed physicians participate in the in-network portion of an insurer's network, shall be deemed "provisionally credentialed" and may participate in the in-network portion of an insurer's network during this time period upon: (A) the insurer's receipt of the hospital and

physician's completed sections of the insurer's credentialing application; and (B) the insurer being notified in writing that the health care professional has been granted hospital privileges pursuant to the requirements of section twenty-eight hundred five-k of the public health law. However, a provisionally credentialed physician shall not be designated as an insured's primary care physician until such time as the physician has been fully credentialed by the insurer. Notwithstanding any other provision of law, an insurer shall not be required to make any payments to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the service provided by a provisionally credentialed physician, until and unless the physician is fully credentialed by the insurer, provided, however, that upon being fully credentialed, the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall be paid for all services provided by the physician for up to sixty days after submission of the completed application that the credentialed physician provided to the insurer's subscribers or members from the date the physician fully met the requirements to be provisionally credentialed pursuant to this paragraph. Should the application ultimately be denied by the insurer, the insurer shall not be liable for any payment to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the services provided by the provisionally credentialed health care professional that exceeds any out-of-network benefits payable under the insured's contract with the insurer; and the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance or deductible amount that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of an insurer's network.

(b) (1) An insurer shall not terminate a contract with a health care professional for participation in the in-network benefits portion of the

insurer's network for a managed care product unless the insurer provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

(2) The notice of the proposed contract termination provided by the insurer to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by the insurer;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing or review; and

(iv) a time limit for a hearing date which must be held within not less than thirty days after the date of receipt of a request for a hearing.

(3) The hearing panel shall be comprised of three persons appointed by the insurer. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.

(4) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the insurer, provisional reinstatement subject to conditions set forth by the insurer or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(5) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision; provided, however, that the provisions of subsection (e) of section four thousand eight hundred four shall apply to such termination.

(6) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

(c) Either party to a contract for participation in the in-network benefits portion of an insurer's network for a managed care product may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for purposes of this section.

(d) An insurer shall develop and implement policies and procedures to ensure that health care providers participating in the the in-network benefits portion of an insurer's network for a managed care product are regularly informed of information maintained by the insurer to evaluate the performance or practice of the health care professional. The insurer shall consult with health care professionals in developing methodologies to collect and analyze provider profiling data. Insurers shall provide any such information and profiling data and analysis to these health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of such a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each such health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the professional's profile and to work cooperatively with the insurer to improve performance.

(e) No insurer shall terminate or refuse to renew a contract for participation in the in-network benefits portion of an insurer's network for a managed care product solely because the health care professional has (1) advocated on behalf of an insured; (2) has filed a complaint against the insurer; (3) has appealed a decision of the insurer; (4) provided information or filed a report pursuant to section forty-four hundred six-c of the public health law; or (5) requested a hearing or review pursuant to this section.

(f) Except as provided herein, no contract or agreement between an insurer and a health care professional for participation in the in-network benefits portion of an insurer's network for a managed care product shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination and the opportunity for a hearing concerning such termination.

(g) Any contract provision in violation of this section shall be deemed to be void and unenforceable.

(h) For purposes of this section, "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.