§ 365-g. Utilization review for certain care, services and supplies. 1. The department may implement a system for utilization review, pursuant to this section, for persons eligible for benefits under this title, to evaluate the appropriateness and quality of medical assistance, and safeguard against unnecessary utilization of care and services, which shall include a post-payment review process to develop and review beneficiary utilization profiles, provider service profiles, and exceptions criteria to correct misutilization practices of beneficiaries and providers; and for referral to the office of Medicaid inspector general where suspected fraud, waste or abuse are identified in the unnecessary or inappropriate use of care, services or supplies furnished under this title.

2. The department may review utilization by provider service type, medical procedure and patient, in consultation with the state department of mental hygiene, other appropriate state agencies, and other stakeholders including provider and consumer representatives. In reviewing utilization, the department shall consider historical recipient utilization patterns, patient-specific diagnoses and burdens of illness, and the anticipated recipient needs in order to maintain good health. The system for utilization review shall not be used to determine a recipient's medical care, services or supplies under this section.

3. The utilization review established pursuant to this section shall not apply to developmental disabilities services provided in clinics certified under article twenty-eight of the public health law, or article twenty-two or article thirty-one of the mental hygiene law.

4. Utilization review established pursuant to this section shall not apply to services, even though such services might otherwise be subject to utilization review, when provided as follows:

(a) through a managed care program;

(b) subject to prior approval or prior authorization;

(c) as family planning services;

(d) as methadone maintenance services;

(e) on a fee-for-services basis to in-patients in general hospitals

certified under article twenty-eight of the public health law or article thirty-one of the mental hygiene law and residential health care facilities, with the exception of podiatrists' services;

(f) for hemodialysis; or

(g) through or by referral from a preferred primary care provider designated pursuant to subdivision twelve of section twenty-eight hundred seven of the public health law.

5. The department shall consult with representatives of medical assistance providers, social services districts, voluntary organizations that represent or advocate on behalf of recipients, the managed care advisory council and other state agencies regarding the ongoing operation of a utilization review system.

6. On or before February first, nineteen hundred ninety-two, the commissioner shall submit to the governor, the temporary president of the senate and the speaker of the assembly a report detailing the implementation of the utilization threshold program and evaluating the results of establishing utilization thresholds. Such report shall include, but need not be limited to, a description of the program as implemented; the number of requests for increases in service above the threshold amounts by provider and type of service; the number of extensions granted; the number of claims that were submitted for emergency care or urgent care above the threshold level; the number of recipients referred to managed care; an estimate of the fiscal savings to the medical assistance program as a result of the program; recommendations for medical condition that may be more appropriately served through managed care programs; and the costs of implementing the program.