

**NEW YORK STATE INSURANCE DEPARTMENT
AND
NEW YORK STATE HEALTH DEPARTMENT**



**External Appeal Program Annual Report
July 1, 1999 - June 30, 2000**

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"This law heralds a new age in health insurance in New York by empowering consumers to get the treatments they need. Treatment decisions should be made for medical reasons and not solely for financial reason by health insurance gatekeepers. New Yorkers now have the ability to challenge the decisions of health insurers to ensure they receive the quality care they deserve."

Governor George E. Pataki

July 1, 1999

Summary of New York's External Appeal Law:

On July 1, 1999, Governor George E. Pataki's landmark external appeal law became effective. A measure that is seen as a benchmark for other states to follow, the external appeal law represents yet another example of New York State's commitment to protecting consumers in New York's health care system, offering New Yorkers some of the strongest protections in the nation.

Under the law, health care consumers have the right to obtain an independent review of a health plan's denial of coverage on the basis of medical necessity or because the services are considered experimental or investigational.¹ To be eligible for an external review, the denial must first be appealed through the health plan's internal appeal process or the health plan and the patient must jointly agree to waive the internal appeal process. A patient then has 45 days from receipt of the final adverse determination from the first level of internal appeal with the health plan or from receipt of a letter from the health plan waiving the internal appeal process to request an external appeal.²

Health plans may charge a fee up to \$50.00 to patients requesting an external appeal. The fee must be waived if the patient has coverage under Medicaid, Child Health Plus or if the plan determines the fee will pose a hardship. The fee is returned to the patient if the denial is overturned by the external appeal agent, or forwarded to the health plan if the denial is upheld.

External appeal requests are submitted to the New York State Insurance Department, which is responsible for screening the requests for eligibility and completeness. The Insurance Department is required to review external appeal requests within 24 hours for expedited appeals or five business days for standard appeals. If the request is complete and eligible for external review, Insurance Department staff will randomly assign the request to an external appeal agent.

External appeal agents have a comprehensive panel of medical experts available to review the appeal. Typically one clinical peer will be assigned to review medical necessity denials while three clinical peers are assigned to review experimental or investigational treatment denials. The external appeal agent has three days to render a determination for expedited appeals and 30 days (plus five business days when additional information is requested) for standard appeals.

The external appeal law requires the Insurance Department and the Health Department to annually report the number of external appeals requested and the outcomes by health plan and by external appeal agent. The purpose of this report is to provide a comprehensive overview of the External Appeal Program in New York for its first year of operation.

¹ Chapter 586 of the Laws of 1998.

² Health plans include health maintenance organizations and insurers. See Section 4900(d-5) of the Insurance Law and Section 4900(4-e) of the Public Health Law.

Background of External Appeal Law:

In 1996 the Managed Care Reform Act was passed in New York. This law included many consumer protections such as requiring access to specialists and continuity of care when a provider is no longer participating in a network; a prudent layperson standard for coverage of emergency services; mandatory disclosure of coverage information to subscribers; prohibitions on gag clauses in provider contracts and requirements for health plans to have a grievance procedure and a utilization review appeal process.³

Under this law, managed care plans are required to have a grievance process for review of all determinations other than medical necessity determinations.⁴ The types of determinations that are subject to the grievance process include access to referral disputes or determinations that a benefit is not covered under the terms of a contract.

Along with a grievance process, the law also requires health plans to have a utilization review process if medical necessity determinations are rendered. Utilization review is defined as the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.⁵ The law establishes standards and timeframes for health plan initial utilization review determinations and also requires plans to have an internal appeal process. The law permits patients, a patient's designee or, in connection with a retrospective adverse determination, the patient's health care provider to appeal an adverse medical necessity determination with the health plan.

The external appeal law builds on the utilization review provisions of the Managed Care Reform Act and provides additional protections for health care consumers. The external appeal law enables consumers to obtain an independent review if a health plan upholds an adverse medical necessity determination on appeal.

³ Chapter 705 of the Laws of 1996.

⁴ Managed care plans are defined as health maintenance organizations, and insurers either offering coverage only through participating providers or offering coverage through participating providers with an out-of-network option that meets certain requirements. See Section 4408-a of the Public Health Law and Section 4801(c) of the Insurance Law.

⁵ Section 4900(h) of the Insurance Law and Section 4900(8) of the Public Health Law.

Implementation of External Appeal Law:

Once the external appeal legislation was signed into law, staff from the Insurance Department and the Health Department began meeting regularly to ensure that an external review program would be operational by the July 1, 1999 effective date imposed by statute. The Insurance Department and the Health Department identified several tasks that had to be completed prior to July 1, 1999 in order for the program to be operational. All tasks were completed prior to July 1, 1999 and the external appeal program was operational on the statutory effective date. The following is a description of the tasks and the completion dates:

Regulations had to be promulgated by both the Insurance Department and the Health Department to implement the legislation and establish external review procedural requirements.

- Regulations were promulgated on an emergency basis by the Insurance Department on June 18, 1999 and by the Health Department on June 21, 1999.

An application for the certification of external appeal agents had to be developed and a process for certifying agents established.

- An external appeal agent application was finalized and posted on the websites of the Insurance Department and the Health Department on April 12, 1999.

Applications submitted by prospective external appeal agents had to be reviewed and those agents, able to meet all requirements, had to be certified.

- All applications were reviewed within three weeks of receipt. Comment letters were sent to prospective agents requesting clarification and modification of application materials. Conference calls were also held with several applicants.
- Island Peer Review Organization (IPRO) was certified on June 30, 1999 and Medical Care Management Corporation (MCMC) was certified on July 2, 1999.

The Insurance Department had to obtain the names and contact information of health plan staff responsible for handling external appeal requests during business and non-business hours so the Department would be able to readily contact health plans when an external appeal request was submitted.

- Contact information was requested from health plans on June 24, 1999 and obtained by July 1, 1999.

A dedicated fax line and a new address had to be established at the Insurance Department for the receipt of external appeal requests so that requests would be kept separate from other mail.

- Both were operational by the last week in June, 1999.

The Insurance Department had to develop a computer system capable of electronically receiving and tracking external appeal applications, including remote access.

- The computer system was developed, tested and operational by June 25, 1999.

The Insurance Department had to develop an internal process for the intake and screening of external appeal requests.

- A process was developed and staff training sessions were conducted on June 11, 1999.

The Insurance Department had to ensure that staff would be available on weekends and holidays to screen expedited external appeal requests submitted during non-business hours.

- Availability was accomplished through the use of an answering service and pagers for on-call staff.

A standard description of the external appeal process and applications for patients and providers to request an external appeal had to be developed and disseminated to health plans.

- A standard description and applications were disseminated to health plans on June 24, 1999 and posted on the websites of the Insurance Department and the Health Department.

Outreach had to be conducted so that consumers and health plans would be made aware of their rights and responsibilities under the new legislation.

- The Insurance Department launched a toll free hotline (1-800-400-8882) on June 10, 1999 to respond to questions concerning the external appeal process.
- External appeal applications and information were posted on the web sites of the Insurance Department and the Health Department beginning in April, 1999.
- The Insurance Department and the Health Department participated in external appeal informational meetings with health plans, providers and consumer groups.
- Brochures describing the new rights with respect to external appeal were developed and disseminated by the Insurance Department.
- Press releases were issued by the Insurance Department in April, 1999 and again in June, 1999 informing interested parties of the progress made in implementation of the external appeal law.

The External Appeal Regulations:

The external appeal law requires the Insurance Department and the Health Department to promulgate regulations to implement an external appeal program. In order to have regulations in effect by July 1, 1999, regulations had to be filed with the Secretary of State on an emergency basis. The Insurance Department first filed its regulation on June 18, 1999 as a new Part 410 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation 166). The Health Department first filed its regulation on June 21, 1999 as a new Subpart 98-2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York.

As emergency measures, the regulations were effective when filed. When a regulation is filed on an emergency basis, the regulation must also be formally proposed by the state agency, published as a proposed notice of rulemaking, and subject to a public comment period, initially of 45 days. If substantive changes are made to the regulation as a result of the public comments, the regulation must be proposed again, published, and subject to another public comment period of 30 days.

Emergency regulations are effective for a limited period of time. Initial emergency filings are effective for 90 days, while subsequent emergency filings are effective for 60 days, in accordance with the requirements of the State Administrative Procedure Act (SAPA). In order to avoid expiration of an emergency measure, an emergency regulation must be re-filed until a proposed regulation is formally adopted because, until the time of adoption, a proposed regulation is just that, proposed, and is not controlling. A regulation may be formally adopted once a public comment period ends if substantive changes are not made to the regulation.

The following chronology describes the regulatory filings made by the Insurance Department and the Health Department subsequent to the initial emergency filings.

- The Insurance Department regulation was re-filed on an emergency basis on September 15, 1999, December 13, 1999, February 10, 2000, April 7, 2000 and June 6, 2000 to prevent the regulation from expiring.
- The Health Department regulation was re-filed on an emergency basis on September 17, 1999, December 17, 1999, February 10, 2000, April 10, 2000 and June 9, 2000 to prevent the regulation from expiring.
- In accordance with the requirements of Executive Order No. 20, the Insurance Department regulation was filed with the Governor's Office of Regulatory Reform (GORR) on June 22, 1999 for review and approval to formally propose the regulation. The Health Department regulation was filed with GORR on June 21, 1999.
- GORR granted the Insurance Department and the Health Department approval on October 27, 1999 to file a proposed notice of rulemaking with the Secretary of State.

- The Insurance Department filed a proposed notice of rulemaking with the Secretary of State on November 3, 1999 for publication in the November 24, 1999 State Register. The Health Department filed a proposed notice of rulemaking with the Secretary of State on November 2, 1999 for publication in the November 17, 1999 State Register. A 45 day public comment period commenced upon publication of the regulations in the State Register.
- Comments were received by both Departments from health plans, providers and consumer groups during the public comment period.
- The regulations were substantively revised based upon public comment and the Insurance Department and the Health Department submitted a revised proposed version of the regulations to GORR on February 17, 2000.
- GORR granted both Departments approval on April 27, 2000 to file a revised notice of proposed rulemaking with the Secretary of State.
- The Insurance Department filed a notice of continuation on April 28, 2000 with the Secretary of State for publication in the May 10, 2000 State Register in order to prevent the proposed regulation from expiring. The Health Department filed a notice of continuation on April 12, 2000 with the Secretary of State for publication in the May 3, 2000 State Register in order to prevent the proposed regulation from expiring.
- The Insurance Department and the Health Department filed a revised notice of proposed rulemaking with the Secretary of State on May 12, 2000 for publication in the May 31, 2000 State Register and commencement of a 30 day public comment period.
- The most recent public comment period expired June 30, 2000. If substantive changes are made to the regulations based upon public comment, a revised proposed version of the regulations must be submitted to GORR for approval to file a revised notice of proposed rulemaking with the Secretary of State. If substantive changes are not made, the regulations may be formally adopted.

Staffing for External Appeal Program:

The Insurance Law and the Public Health Law provide that the Insurance Department and the Health Department shall be jointly responsible for implementation of the external appeal legislation, certification and oversight of external appeal agents, and oversight and monitoring of the external appeal process. The regulations of both Departments provide that the Insurance Department shall be responsible for screening external appeal requests for eligibility and completeness and for assigning requests to external appeal agents.

Neither the Insurance Department nor the Health Department hired new staff to administer the external appeal program. All work associated with the external appeal program has been performed by existing staff. Insurance Department attorneys in the Health Bureau and Health Department staff in the Office of Managed Care are responsible for certification and oversight of external appeal agents and for monitoring health plan compliance with external review requirements.

Five staff members in the Insurance Department's Consumer Services Bureau and one Insurance Department attorney in the Health Bureau are responsible for screening external appeal requests for eligibility and completeness, for assigning appeals to external appeal agents and for responding to calls on the external appeal hotline, in addition to other job responsibilities.

Due to the unanticipated high volume of external appeal requests, additional staffing for the external appeal program is necessary and will be requested.

Types of Determinations Eligible for External Review and Standards Used For Review:

To be eligible for external review, services must be denied on the basis of medical necessity or as experimental or investigational. In addition, the denial must first be appealed internally with the health plan, unless the patient and the health plan jointly agree to waive the internal appeal process.

Medical Necessity External Appeals:

- Generally, patients do not need an attestation from their attending physician in order to request an external appeal of a medical necessity determination.
- An attending physician attestation is only required if a patient would like their external appeal to be expedited.
- The standards the external appeal agent must apply when reviewing a medical necessity determination are imposed by statute and the health plan's definition of medical necessity is not determinative.⁶
- When reviewing a medical necessity determination, the external appeal agent must determine whether the health plan acted reasonably, with sound medical judgement and in the best interest of the patient. The external appeal agent must consider the clinical standards of the plan, the information provided concerning the patient, the attending physician's recommendation and applicable and generally accepted practice guidelines.

Experimental/Investigational External Appeals:

- In order for a patient to be eligible for an external review of an experimental or investigational determination, a patient's attending physician must attest that the patient has a life-threatening or disabling condition or disease for which a more beneficial standard procedure does not exist, would be ineffective, or for which there exists a clinical trial.
- The patient's attending physician must also either have recommended a health service that, based upon two documents from the available medical and scientific evidence, is likely to be more beneficial than a standard treatment or, the attending physician must have recommended a clinical trial for which the patient is eligible.
- The off-label use of prescription drugs is also included within the scope of experimental or investigational denials eligible for external review.

⁶ See Section 4914(b)(4)(A) of the Insurance Law and Section 4914(2)(d)(A) of the Public Health Law.

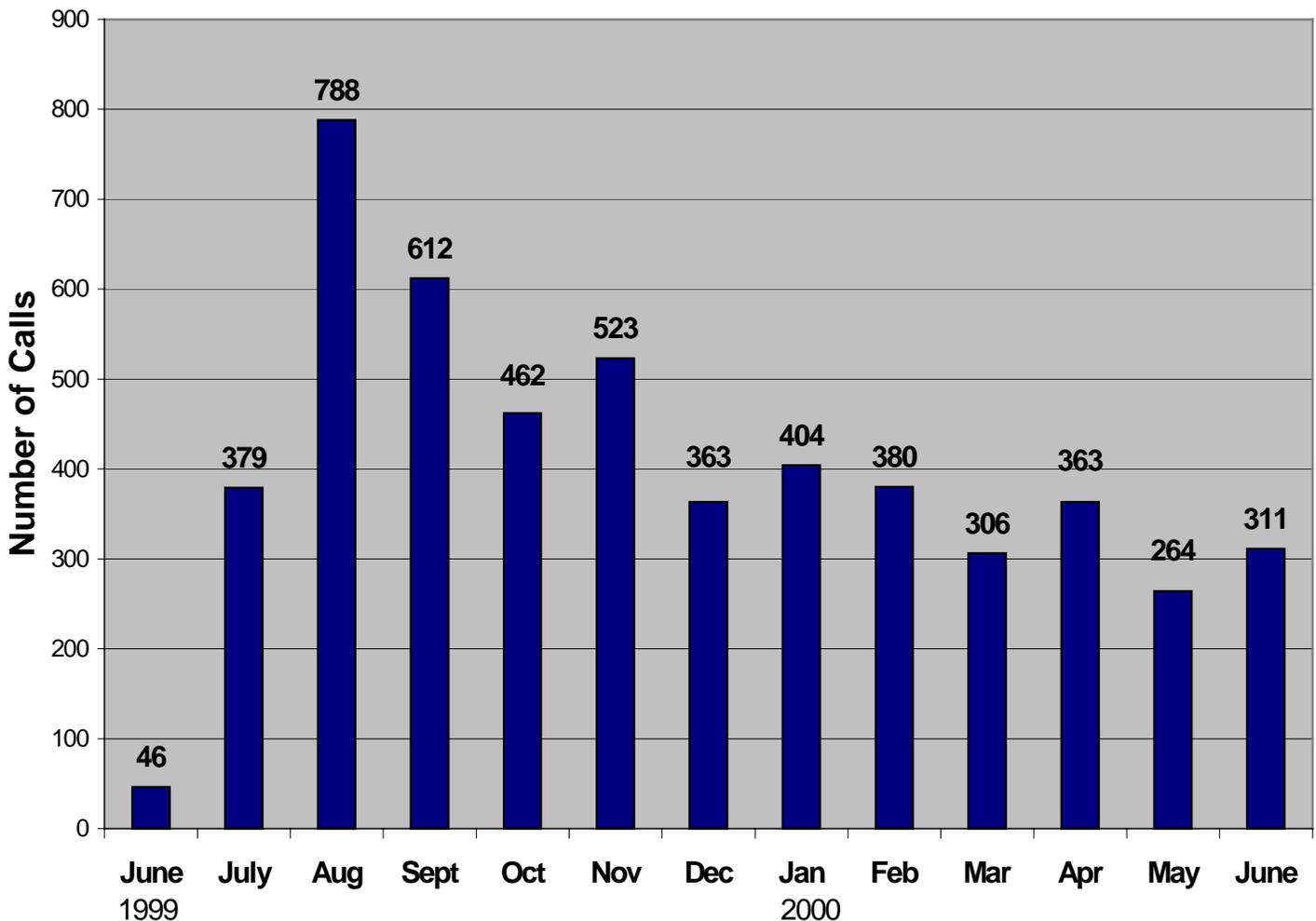
- When reviewing an experimental/investigational treatment appeal, the external appeal agent must determine whether the services are likely to be more beneficial than any standard treatment.
- When reviewing an appeal involving a clinical trial, the external appeal agent must determine whether the trial is likely to benefit the patient.

Volume of External Appeal Hotline Calls:

The Insurance Department launched an external appeal hotline so that consumers would be able to effectively utilize their important new external appeal rights. Calls to the hotline are answered by designated and trained staff from the Insurance Department's Consumer Services Bureau. Attorneys from the Insurance Department's Health Bureau are also available to respond to questions. Hotline operators provide external appeal information and assist consumers in filing external appeal requests.

A total of 5,201 calls were received on the external appeal hotline during the first year of operation, demonstrating that the hotline has, and continues to provide a valuable service to consumers. The following chart identifies the number of calls received each month on the external appeal hotline from June 10, 1999 through June 30, 2000.

Incoming Calls to the Toll-Free External Appeal Hotline 1-800-400-8882

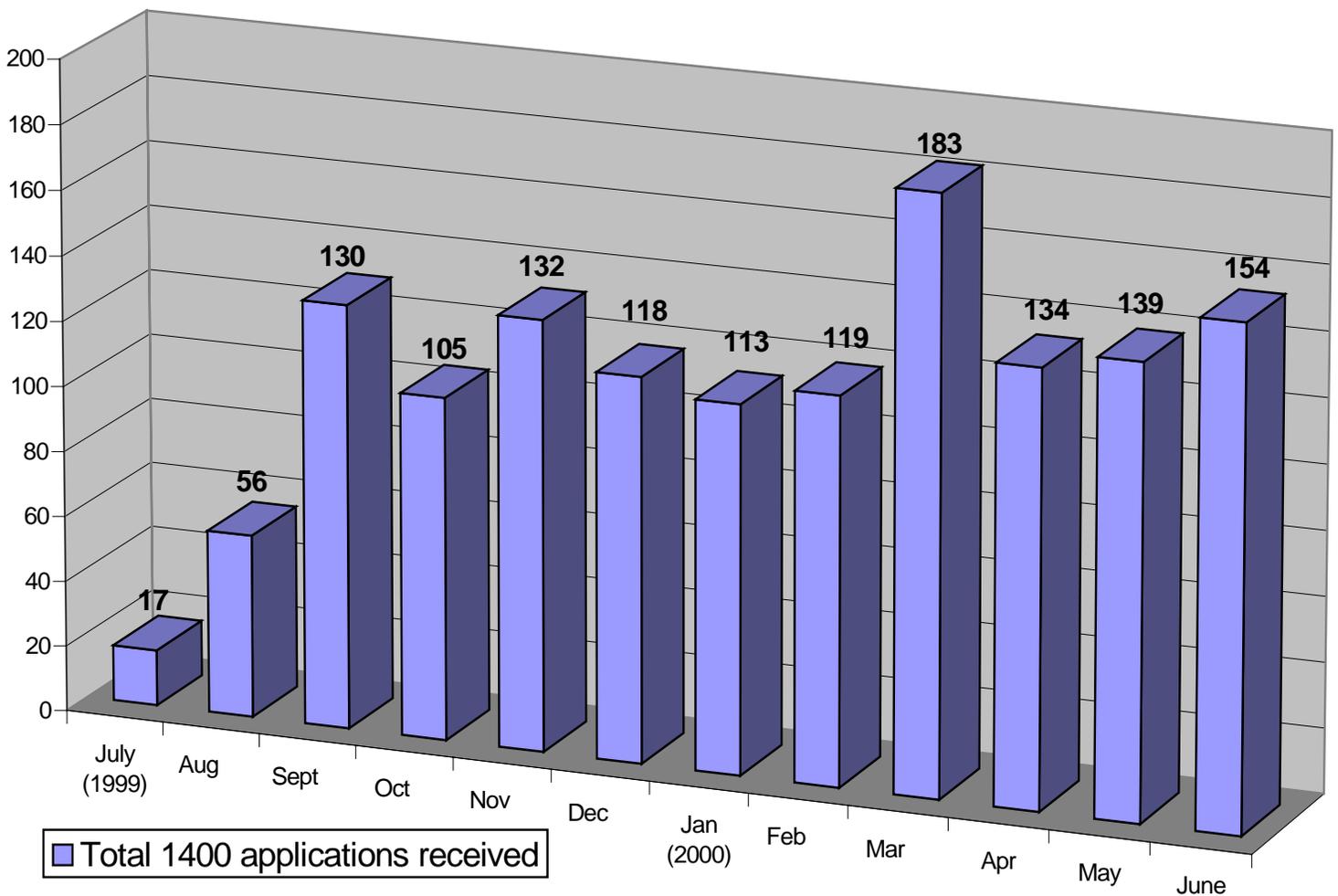


Volume of External Appeal Requests:

When implementing the legislation, staff from the Insurance Department and the Health Department spoke with representatives from other states with an external appeal program to discuss the external appeal process, issues encountered, and the volume of appeals. The Departments also reviewed published reports detailing the volume of external appeals in states with a mandated right to external appeal. Based upon the information provided by other states, and a review of the published reports, staff anticipated that less than 200 external appeal requests would be submitted to the Insurance Department on an annual basis.

From July 1, 1999 through June 30, 2000, the Insurance Department received 1400 external appeal requests. The following chart identifies the volume of external appeal requests received by the Insurance Department for each month the program has been operational.

External Appeal Applications Received by the Insurance Department between July 1, 1999 and June 30, 2000



Frequent Use of the External Appeal Program:

New York has received a significantly high volume of external appeal requests when compared to other states. One possible reason for the high volume is that potential barriers to consumer access have been minimized. In November, 1998 and again in May, 2000 the Kaiser Family Foundation released reports identifying features of external appeal programs that could pose barriers to consumer access.⁷ These reports identified a lack of public awareness, the length of the internal and external appeal process, filing fees, external appeal filing deadlines, claims thresholds and limits on types of cases eligible for external review as potential barriers.⁸ The following is a discussion of how these potential barriers have been addressed in New York.

Public Awareness:

The volume of external appeals may be attributed, in part, to the outreach conducted by the Insurance Department and the Health Department. Both Departments have committed resources to ensure that consumers are made aware of their external appeal rights, to assist consumers in the filing of appeals and to ensure that the external appeal process is not cumbersome.

- Both Departments have participated in informational seminars throughout the state with providers, health plans and consumers in order to disseminate information on the external appeal process.
- The Insurance Department established an external appeal hotline to assist New Yorkers in filing external appeal requests and to answer any questions applicants may have.
- Insurance Department staff is available on weekends and holidays to handle expedited external appeal requests and to assist patients with the filing of expedited requests.
- Information about the external appeal process and applications for consumers and providers to request an external appeal are available on the websites of the Insurance Department at www.ins.state.ny.us and the Health Department at www.health.state.ny.us.

⁷ See, Karen Pollitz, Geraldine Dallek, and Nicole Tapay, "External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare," prepared for the Kaiser Family Foundation, November 1998. See also, Geraldine Dallek and Karen Pollitz, "External Review of Health Plan Decisions: An Update", prepared for the Kaiser Family Foundation, May 2000.

⁸ See, Pollitz, Dallek, and Tapay, "External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare," p. 5-6. See also, Dallek and Pollitz, "External Review of Health Plan Decisions: An Update", p. 1-4.

In addition to outreach efforts, both the Insurance Department and the Health Department monitor compliance and promote enforcement of the external appeal law, especially in relation to requirements for disclosure of external appeal information to consumers.

- The external appeal law requires health plan member handbooks and subscriber contracts to include external appeal information.
- The external appeal law and regulations also require health plans to notify subscribers, in writing, of their external appeal rights at the time an adverse medical necessity or experimental/investigational appeal determination is rendered. In addition, health plans must enclose an external appeal application and information with the denial.
- When handling consumer complaints, both the Insurance Department and the Health Department advise complainants of their external appeal rights if the complaint appears to raise issues addressed by the external appeal law. In addition, both Departments provide assistance to complainants who would like to file an external appeal request.

Length of Appeal Process:

The timeframes for internal and external appeal in New York are comparable to those in other states.⁹ However, health plans in New York are not permitted to impose more than one level of internal appeal before providing the patient access to the external appeal process. In addition, appeals may be expedited both internally and externally and, if that occurs, the entire process will take approximately a week so that delays are avoided. New York law also permits the patient and the health plan to jointly agree to waive the internal appeal process and proceed directly to an external appeal, again so that delays can be avoided.

The internal and external appeal timeframes have not appeared to present a barrier to access in New York because there are protections in place for expedited cases, prohibitions on requiring more than one level of internal appeal for external appeal eligibility, and flexibility to enable the health plan and the patient to waive the internal appeal process. In addition, the law is designed to ensure that health plans meet the internal appeal timeframe because, if the timeframe is not met, the service must be provided and an external appeal is not necessary.

⁹ Health plans must make an initial utilization review determination within three business days for pre-authorization requests, one business day for continued services and thirty days for services that have already been provided. Health plans must render an appeal determination within two business days for expedited appeals or 60 days for standard appeals. External appeal agents must render a determination in three days for expedited appeals and 30 days for standard appeals. See Article 49 of the Insurance Law and Article 49 of the Public Health Law.

Filing Fee:

Plans may impose a filing fee of up to \$50.00 for an external appeal, however, there are protections in place in relation to the fee so that the fee will not present a barrier to access.

- The fee may not be charged to patients who receive medical assistance such as Medicaid or Child Health Plus.
- Patients who do not receive medical assistance may request a fee waiver if the fee will pose a hardship. If a patient's application indicates that a fee waiver has been requested, the application is processed without delay or verification from the health plan that the patient meets the plan's criteria for hardship.
- If an expedited appeal request is submitted by facsimile and a fee is required, the request is processed immediately and the applicant is requested to mail the fee to the Insurance Department within three business days.
- If an external appeal agent overturns the health plan's determination, in whole or in part, the fee is returned to the patient.
- The fee must be in the form of a check or money order made payable to the health plan. The Insurance Department merely holds the fee and does not cash the check or money order.

Filing Deadline:

External appeal applications must be submitted to the Insurance Department within 45 days of the applicant's receipt of the final adverse determination from the first level of internal appeal with the health plan.

The law and regulations ensure that patients are made aware of the 45 day timeframe. Health plan final adverse determination letters must advise patients of the timeframe for requesting an external appeal. External appeal applications also advise applicants of the 45 day timeframe.

Additional consumer protections are also in place with respect to the timeframe. When Insurance Department staff reviews an external appeal application to determine whether the timeframe was met, it is presumed that the applicant received the final adverse determination within eight days of the date on the determination. An external appeal application is also considered timely if submitted within the requisite timeframe, regardless of whether the application is complete. When incomplete applications are submitted, Insurance Department staff will notify the applicant, identify the missing information, and assist the applicant in completing the application.

Limits on Eligibility:

The New York external appeal law is broad in application and limits on eligibility are minimal. Disputes concerning medical necessity, experimental and investigational services, clinical trials and the off-label use of prescription drugs are eligible for external review in New York. There is no requirement that the claim have a minimum dollar value.

Access to a referral to a non-participating provider or review of the appropriateness of a particular coding to a patient, including the assignment of diagnosis and procedure are not subject to the external review process. Disputes concerning benefit or coverage limitations are also not eligible for external review.¹⁰

Questions have arisen as to the distinction between medical necessity determinations and disputes concerning coverage or benefit limitations. Denials because a contractual visit limit has been exceeded or denials because a benefit itself is not covered under the contract are not eligible for external review. Cosmetic, custodial and convenience item determinations are, however, considered medical necessity determinations, subject to the external appeal process.

¹⁰ See Section 4802(b)(1) and Section 4900(h) of the Insurance Law and Section 4408-a(2)(a) and Section 4900(8) of the Public Health Law.

The Insurance Department's Screening of External Appeal Requests:

External appeal requests are submitted to the Insurance Department which is responsible for screening requests for eligibility and completeness.

Completeness:

When screening an external appeal request for completeness, Insurance Department staff reviews the application to ensure that:

- The application has been completed and is signed.
- A final adverse determination from the first level of appeal with the health plan is included.
- The applicant has enclosed a check for the application fee made payable to the health plan, or the applicant has indicated the fee does not apply or a fee waiver has been requested.
- An attending physician attestation has been fully completed if the appeal is expedited or if the services are experimental or investigational.

If a request is determined to be incomplete, a letter identifying and requesting the missing information is sent to the patient, and the attending physician as appropriate. An address for the submission of the information is provided and a timeframe for submitting the information is included. The name and telephone number of the Insurance Department staff member reviewing the appeal is also provided so that the patient may readily contact the staff member with any questions. If the appeal is expedited, the request for the missing information is made by telephone, followed by written notice.

Eligibility:

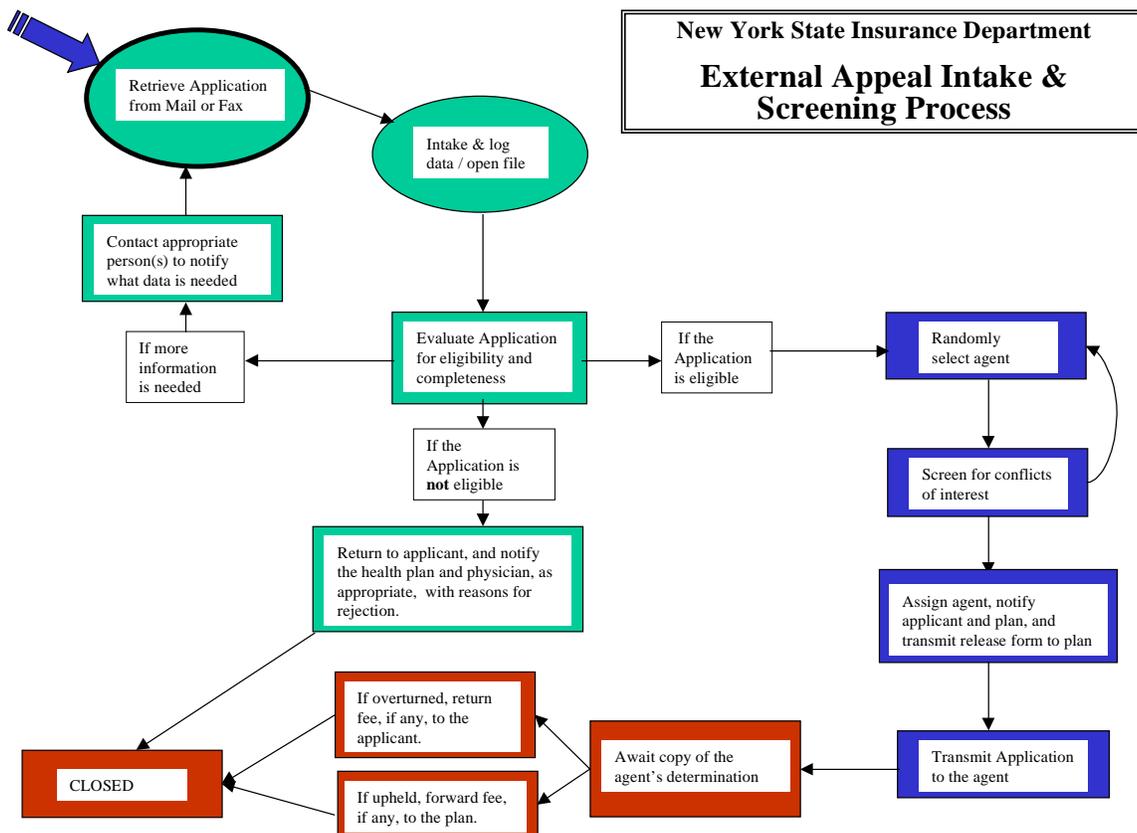
When screening an application for eligibility, Insurance Department staff reviews the application to ensure that:

- A final adverse determination from the first level of internal appeal with a health plan has been rendered. If the application is ineligible because a final adverse determination has not yet been rendered, the patient is advised to appeal internally with the health plan within the requisite timeframe and then, if necessary, request an external appeal.
- The 45 day timeframe has not been exceeded. An application is considered timely if submitted to the Insurance Department within 45 days of receipt of the final adverse determination from the first level of internal appeal with the health plan. It is presumed that the final adverse determination was received within eight days of the date on the determination.
- Services have been denied on the basis of medical necessity or as experimental or investigational. The denial letter from the health plan is used to determine the basis of the denial. However, if external appeal rights are not provided, staff from the Insurance Department reviews the denial to ensure that it is not one that falls within the scope of what should be considered a medical necessity or experimental/investigational denial. If it appears that a decision involving medical necessity or experimental/investigational services has been

made, the Insurance Department will contact the health plan and request that external appeal rights be provided.

- The type of coverage falls within the scope of the law. The New York external appeal law is not applicable to self-insured plans, out-of-state insurance policies, workers compensation coverage, no-fault automobile coverage, Medicaid fee-for-service coverage and Medicare coverage, including coverage under Medicare managed care plans.
- The denial is not based upon a request for a referral to a non-participating provider, failure to obtain health services from a designated provider, reimbursement amounts or the appropriateness of a particular procedure coding.
- If services are denied as experimental or investigational, an attending physician must have attested that the patient has a life-threatening or disabling condition or disease and that standard health services have been ineffective or would not be more beneficial than the proposed treatment. In addition, the attending physician must submit two articles of medical and scientific evidence in support of the recommended procedure and must attest that the information submitted meets the definition of medical and scientific evidence. If the attending physician attestation does not meet all of these requirements, the external appeal request will not be eligible.

The following flow chart illustrates how applications proceed through the Insurance Department's screening process.



Rejection of External Appeal Requests:

Supervisory approval is required before an external appeal request may be rejected by Insurance Department staff. If an application is rejected, the application and the fee are returned to the applicant and an explanation of why the application has been rejected is provided. Applicants are also advised that even though the request is not eligible for external review, they may still request that the matter be reviewed and handled by staff from the Office of Managed Care in the Health Department or the Consumer Services Bureau in the Insurance Department.

From July 1, 1999 to June 30, 2000, during the first year of the program, 421 external appeal requests were rejected. In the initial months, a predominate reason for rejection was because the external appeal related to an adverse determination rendered before the law became effective. As the months progressed, this reason for rejection became less prevalent.

When the results for the entire year are considered, the most frequent reason for rejection of external appeal requests was because an application was incomplete and the applicant did not provide the missing information after two requests for the information were made by Insurance Department staff.¹¹

Another reason for rejection was because providers submitted applications when ineligible to request an external appeal under the law. The law states that providers may request an external appeal of a retrospective adverse determination. Given this limitation, provider applications involving pre-authorization determinations or concurrent review were rejected.

Some external appeal requests were rejected because the health insurance coverage was not within the scope of the New York external appeal law. The external appeal law does not apply to self-insured coverage, out-of-state insurance policies, federal employee health benefits coverage, no-fault automobile coverage and Medicare managed care coverage.

Appeals involving disputes exempted by law from the external appeal process were also rejected. Examples of these types of disputes include contractual disputes, referrals to providers, levels of reimbursement and procedure coding.

The following chart lists the numbers of appeals that have been rejected and the reasons for rejection of external appeal requests.

¹¹ When an incomplete application is submitted, Insurance Department staff sends the applicant (and the applicant's attending physician, as appropriate) a letter requesting the missing information and identifying a timeframe for the submission of the information. The applicant is also encouraged to contact the Department if the applicant requires assistance or has any questions in relation to the information requested. If the information is not received within the timeframe, a second letter is sent identifying a date that the appeal will be rejected if the information is not received. If the information is not received by that date, and the applicant has not contacted the Department, the application is rejected.

Reasons for Rejection of External Appeal Applications
July 1, 1999 - June 30, 2000

Applicant did not provide missing information	90
Provider ineligible to request external appeal	74
Application was not submitted within 45 day timeframe	58
Self-insured coverage	34
Final adverse determination rendered prior to 7/1/99	32
Covered benefit dispute / contract dispute	29
Internal appeal not rendered	25
Access to non-participating provider	14
CPT code, UCR and level of reimbursement dispute	13
Attending physician attestation did not meet requirements of law	12
Medicare managed care coverage	12
Applicant withdrew external appeal request	8
Duplicate application submitted	6
Out-of-state insurance policy	5
Failure to request pre-authorization as basis for denial	5
Loss of coverage / not covered at time of treatment	2
Federal employee coverage	1
No-fault automobile coverage	1
Total	421

Reversals by Health Plans:

A health plan may reverse its adverse determination during the external appeal process, at any time, until the external appeal agent renders a determination. Some denials are reversed by the health plan prior to assignment of an external appeal agent, while others are reversed by the health plan because new information is forwarded to the plan as a result of the external appeal.

Insurance Department staff contacts the health plan prior to assigning an external appeal to an agent in order to provide the plan with early notice that an appeal is eligible for external review. The initial contact also provides an opportunity for staff from the Insurance Department and the health plan to discuss whether the plan would like to reverse its adverse determination. In some cases the dispute is resolved through the Insurance Department's early intervention and review by an external appeal agent is not necessary.

A health plan may also decide to reverse its adverse determination when the case is pending with an external appeal agent. The law requires agents to provide health plans with a copy of any material information submitted with an external appeal that had not previously been reviewed by the health plan. The health plan then has three days to consider the information and must decide whether to reverse its denial or to proceed with the external appeal.

From July 1, 1999 through June 30, 2000, 169 appeals were closed because of health plan reversal of an adverse determination during the external appeal process.

Assignment of External Appeal Requests to Agents:

If an external appeal request is determined to be eligible and complete, staff at the Insurance Department will contact the health plan, the applicant and the external appeal agent.

Health Plan:

The Insurance Department provides the health plan with the name and contact information for the assigned agent, with a reminder that the plan must send medical records to the external appeal agent within three business days from when the agent contacts the plan for standard appeals, or 24 hours from when the agent contacts the plan for expedited appeals. The Insurance Department also advises the health plan whether the appeal will be processed as standard or expedited. The Department provides the health plan with a copy of the plan's own final adverse determination, along with the patient's signed consent to the appeal and release of medical records, so that the plan is made aware of the services being appealed and has the appropriate authorization to release the patient's medical records to the external appeal agent.

Applicant:

A letter is sent to the applicant advising the applicant that the appeal has been assigned to an external appeal agent and agent contact information is provided. The applicant is advised that all materials included with the application have been sent to the agent and that any additional information the applicant would like to submit must be sent immediately to the agent.

Agent:

The Insurance Department sends the application and all information submitted with the application to the external appeal agent by facsimile or overnight mail, depending on the volume and nature of information submitted, and the type of appeal requested. The agent is advised whether the appeal is standard or expedited and whether the denial is based on medical necessity, experimental/investigational services or a clinical trial.

The external appeal agent is responsible for requesting medical records from the health plan and for advising the patient that any additional information must be submitted within the requisite timeframe.

Decisions of External Appeal Agents:

External appeal agents must render a decision in 3 days for expedited appeals and 30 days (plus five business days when additional information is requested) for standard appeals. Pursuant to the law, medical necessity decisions must include the reasons for the determination and, if the plan's denial is upheld on appeal, the clinical rationale, if any, for such determination.

The law provides that decisions involving experimental or investigational treatments must include a written statement as to whether the proposed treatment is likely to be more beneficial than any standard treatment for a patient's life-threatening or disabling condition or disease. Decisions involving a clinical trial must include a written statement as to whether the clinical trial is likely to benefit the patient in the treatment of the patient's life-threatening or disabling condition or disease.

The decision of the external appeal agent is subject to the terms and conditions of the patient's coverage with the health plan, such as cost-sharing requirements or maximum visit limits. The decision of the external appeal agent is binding, but admissible in court proceedings.

Questions have been raised as to the precedential value of the decisions of external appeal agents with respect to coverage of types of services. The decisions of external appeal agents should not be considered of precedential value because they are patient-specific. The decisions focus on the medical history and treatment plan for a particular patient. Frequently, a denial of a particular service will be upheld for one patient and overturned for another.

External Appeal Agents:

The law and regulations impose standards for the certification of external appeal agents. Both are designed to ensure that agents provide an independent review of a health plan's determination through a comprehensive network of qualified providers.

Conflict of interest standards are included in the law and regulations so that external appeal agents will be independent from the health plan and any party involved in the external appeal. External appeal agents are prohibited from having a material professional affiliation, material financial affiliation or material familial affiliation with the health plan, patient, provider or facility involved in the external appeal and/or proposing to provide services. External appeal agents are also prohibited from reviewing a decision if they have reviewed the case for the health plan during the plan's internal appeal process.

The Insurance Department and the external appeal agent are both responsible for reviewing cases to make sure that a conflict of interest does not exist with respect to the agent at the time an appeal is assigned. The agent is further responsible for ensuring that a conflict of interest does not exist with respect to its clinical peers assigned to the appeal and must attest that no conflict of interest exists.

The law and regulations governing external appeal agents also emphasize clinical expertise. External appeal agents must demonstrate that they have a panel of clinical peer reviewers qualified to review both medical necessity and experimental and investigational treatment determinations. The law further requires external appeal agents to assign the appeal to a clinical peer in the same or similar specialty as the provider that typically manages the medical condition that is the subject of the appeal to ensure that the case will be reviewed by a provider of the appropriate specialty. There are also requirements for the agent to have a medical director who is responsible for supervision and oversight of the external appeal process.

The Insurance Department and the Health Department are jointly responsible for reviewing applications for external appeal agent certification. Once certified, external appeal agents must be re-certified every two years.

To date eleven applications requesting certification have been submitted and reviewed:

- Two applicants withdrew their applications after receiving comment letters from the Departments.
- Four applicants were rejected because they were unable to meet the standards imposed by law and regulation.
- Three applications are pending, awaiting responses to comment letters sent by the Departments.
- Two applicants, IPRO and MCMC were certified.

Island Peer Review Organization (IPRO):

Island Peer Review Organization, (IPRO), located in Lake Success, New York was certified on June 30, 1999 as an external appeal agent to conduct external reviews in New York. IPRO has over 15 years experience as a health care quality evaluation organization. IPRO has a network of more than 1,000 clinical peer reviewers with the expertise to provide a full range of external reviews.

Medical Care Management Corporation (MCMC):

Medical Care Management Corporation (MCMC), located in Bethesda, Maryland was certified on July 2, 1999 as an external appeal agent to conduct external reviews in New York. MCMC has been providing external reviews to patients, providers, health plans and employers nationwide, for the past seven years, and has a network that includes more than 500 clinical peer reviewers with the expertise to review all types of appeals.

Cost of External Appeals:

The fees charged by external appeal agents are approved by the Insurance Department and the Health Department for two year periods. The fees must be reasonable, and must be inclusive of indirect costs, administrative fees and incidental expenses.

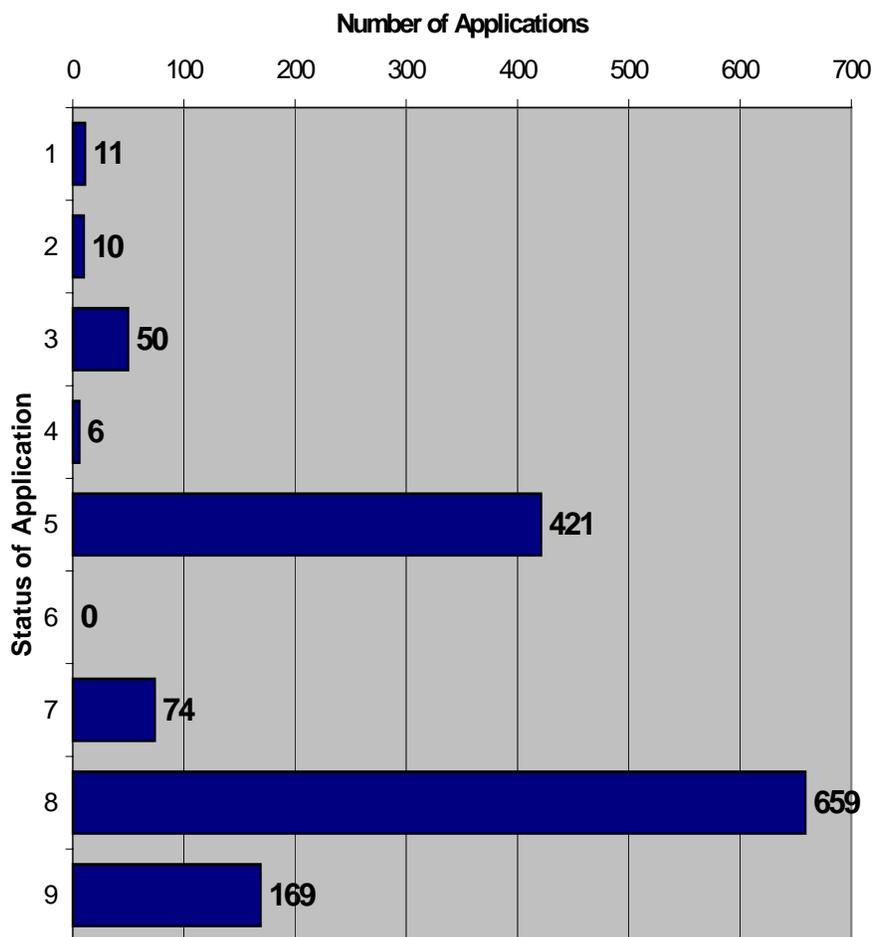
Health plans are responsible for paying the costs of the external appeal regardless of whether the health plan's determination is upheld or overturned by the agent. Payment must be made by the health plan to the external appeal agent within 45 days from the date the appeal determination is received by the health plan. If payment is not made within the 45 days, the plan is required to pay the agent interest at a statutorily prescribed rate.

The cost to all health plans for external appeal determinations rendered from July 1, 1999 through June 30, 2000 totals \$444,275. The fees charged for standard and expedited medical necessity appeals totaled \$331,735, while the fees charged for standard and expedited experimental/investigational appeals and appeals involving clinical trials totaled \$112,540.

Status of External Appeal Requests as of June 30, 2000:

External appeal requests submitted to the Insurance Department are assigned a status code which is automatically updated as the status of the request changes. Status codes identify whether the application is pending Insurance Department review, pending receipt of additional information, under review by an external appeal agent, rejected, reversed by a health plan, or closed because an external appeal agent has rendered a determination. The following chart identifies the status of the 1400 external appeal requests submitted to the Insurance Department as of June 30, 2000:

Status of Applications Received by the Insurance Department as of June 30, 2000



Status codes

- 1 - Pending department review
- 2 - Pending additional info from doctor
- 3 - Pending additional info from applicant
- 4 - Pending additional info from health plan
- 5 - Rejected
- 6 - Awaiting agent assignment
- 7 - At agent
- 8 - Closed (decision rendered by agent)
- 9 - Reversed by health plan

Total applications = 1400

External Appeal Results By Health Plan:

The results from July 1, 1999 through June 30, 2000 reveal that 659 decisions were rendered by external appeal agents. External appeal agents overturned the denial of the health plan in 331 cases and upheld the denial of the health plan in 328 cases. Throughout the duration of the external appeal program, external appeal agents have typically upheld the denial of health plans in half of the cases and overturned the denial in the other half.

External appeal agents are permitted to overturn a health plan's determination in whole or in part. Appeals that have been overturned in part are counted as overturned in the charts below.

The first chart identifies the total number of appeal determinations rendered for all health plans. The following chart organizes health plans into five categories: HMOs, non-profit indemnity insurers, commercial insurers, plans providing Medicaid managed care coverage and municipal cooperative health benefit plans.

When reviewing the charts it is important to keep in mind that some health plans provide coverage to greater numbers of New Yorkers than others. Larger plans may have more external appeals than smaller plans because more people are covered under the plan.

**External Appeal Decisions by Health Care Plan
(listed alphabetically)**

Health Plan	Total	Overturned	Upheld
Aetna/U.S. Healthcare, Inc.	31	19	12
Anthem Health and Life Ins. Co. of NY	1	1	0
Blue Choice (BC/BS Rochester/Finger Lakes)	6	3	3
Buffalo Community Health, Inc.	1	0	1
CDPHP (Capital District Physicians Health Plan)	7	5	2
CIGNA HealthCare of New York	7	3	4
Community Blue (BC/BS Western NY-Buffalo)	13	4	9
Connecticut General Life Ins. Co.	4	0	4
Empire Blue Cross Blue Shield	71	34	37
Empire Blue Cross Blue Shield Healthnet	21	14	7
Excellus (BC/BS of Central NY)	31	13	18
Excellus (BC/BS of Rochester)	3	1	2
Excellus (BC/BS of Utica-Watertown)	4	3	1
Fidelis Care New York (NYS Catholic Health Plan)	3	0	3
GHI	70	47	23
Guardian Life Ins. Co. of America	1	0	1
Health Now (BS of Northeastern NY – HMO)	8	3	5
Health Now (BS of Northeastern NY – Indemnity)	10	7	3
Health Now (BC/BS of Western NY – Indemnity)	7	3	4
Health Plus	2	0	2
Healthsource HMO of NY, Inc.	1	0	1
HIP (Health Insurance Plan of Greater NY)	17	10	7
HMO Blue (Utica-Watertown Health Insurance Co.)	2	1	1
HMO-CNY	4	2	2
Horizon Healthcare Ins. Co. of NY	1	1	0
Independent Health Association (IHA)	4	1	3
Kaiser Permanente	4	2	2
Managed HealthCare Systems	1	1	0
MD:NY	3	3	0
Metropolitan Life Ins. Co.	51	26	25
MVP (Mohawk Valley PHP)	7	0	7
North American Healthcare, Inc.	3	2	1
Oxford Health Plan	118	47	71
Partner’s Health Plans (HUM)	1	1	0
Phoenix Home Life Mutual Ins. Co.	1	0	1
Physicians Health Services	31	19	12
Preferred Care (Rochester Area HMO)	2	2	0
Prudential Health Care Plan of New York, Inc.	8	4	4
Putnam/Northern Westchester Health Benefits Consortium	1	0	1
UniCARE Life and Health Ins. Co.	1	1	0
Union Labor Life Ins. Co.	1	0	1
United HealthCare Ins. Co. of NY Inc.	37	18	19
United HealthCare of New York, Inc.	7	5	2
U.S. Life Ins. Co. in the City of NY	1	0	1
Univera Healthcare CNY	5	2	3
Univera Healthcare WNY	19	6	13
Vytra Healthcare of Long Island	27	17	10
Total	659	331	328

**External Appeal Decisions by Health Care Plan
(listed by type of coverage)**

Health Maintenance Organizations	Total	Overturned	Upheld
Aetna/U.S. Healthcare	31	19	12
Blue Choice (BC/BS Rochester/Finger Lakes)	6	3	3
CDPHP (Capital District Physicians Health Plan)	7	5	2
CIGNA HealthCare of New York	7	3	4
Community Blue (BC/BS Western NY-Buffalo)	13	4	9
Empire Blue Cross Blue Shield Healthnet	21	14	7
Health Now (BS of Northeastern NY)	8	3	5
Healthsource HMO of NY, Inc.	1	0	1
HIP (Health Insurance Plan of Greater NY)	15	9	6
HMO Blue (Utica-Watertown Health Insurance Co.)	2	1	1
HMO-CNY	4	2	2
Independent Health Association (IHA)	4	1	3
Kaiser Permanente	4	2	2
MD:NY	3	3	0
MVP (Mohawk Valley PHP)	7	0	7
North American Healthcare, Inc.	3	2	1
Oxford Health Plan	118	47	71
Partner's Health Plans (HUM)	1	1	0
Physicians Health Services	31	19	12
Preferred Care (Rochester Area HMO)	2	2	0
Prudential Health Care Plan of New York, Inc.	8	4	4
United HealthCare of New York, Inc.	7	5	2
Univera Healthcare CNY	5	2	3
Univera Healthcare WNY	19	6	13
Vytra Healthcare of Long Island	27	17	10
Totals	354	174	180
Non-Profit Indemnity Insurers	Total	Overturned	Upheld
Empire Blue Cross Blue Shield	71	34	37
Excellus (BC/BS of Central NY)	31	13	18
Excellus (BC/BS of Rochester)	3	1	2
Excellus (BC/BS of Utica-Watertown)	4	3	1
GHI	70	47	23
Health Now (BC/BS of Western NY - Indemnity)	7	3	4
Health Now (BS of Northeastern NY - Indemnity)	10	7	3
Totals	196	108	88

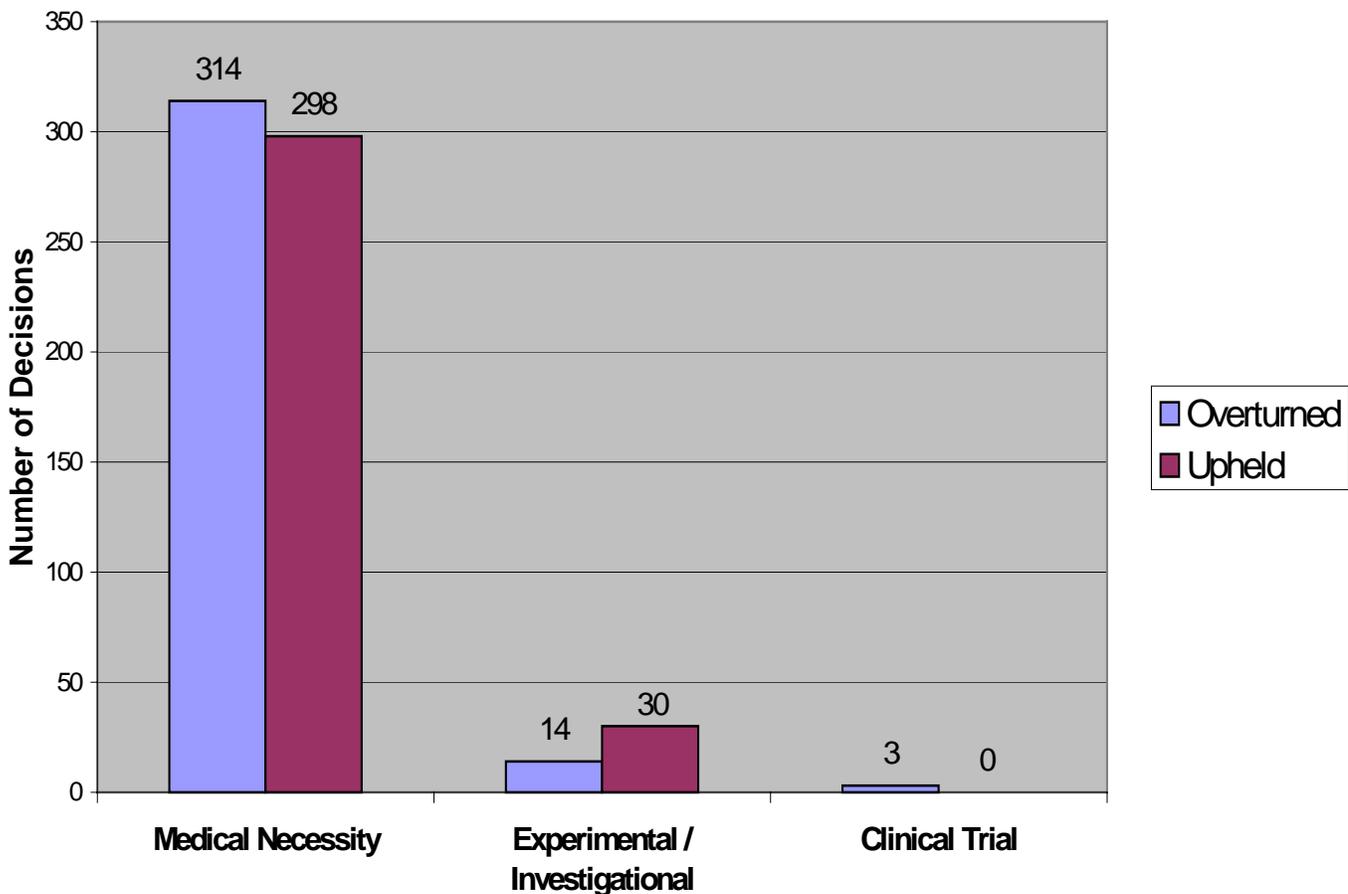
Commercial Insurers	Total	Overturned	Upheld
Anthem Health and Life Ins. Co. of NY	1	1	0
Connecticut General Life Ins. Co.	4	0	4
Guardian Life Ins. Co. of America	1	0	1
Horizon Healthcare Ins. Co. of NY	1	1	0
Metropolitan Life Ins. Co.	51	26	25
Phoenix Home Life Mutual Ins. Co.	1	0	1
UniCARE Life and Health Ins. Co.	1	1	0
Union Labor Life Ins. Co.	1	0	1
United HealthCare Ins. Co. of NY	37	18	19
U.S. Life Ins. Co. in the City of NY	1	0	1
Totals	99	47	52
Medicaid Managed Care Coverage			
Medicaid Managed Care Coverage	Total	Overturned	Upheld
Buffalo Community Health, Inc.	1	0	1
Fidelis Care New York (NYS State Catholic Health Plan)	3	0	3
Health Plus	2	0	2
HIP (Health Insurance Plan of Greater NY)	2	1	1
Managed HealthCare Systems	1	1	0
Totals	9	2	7
Municipal Cooperative Health Benefit Plans			
Municipal Cooperative Health Benefit Plans	Total	Overturned	Upheld
Putnam/Northern Westchester Health Benefits Consortium	1	0	1
Totals	1	0	1
Totals for all decisions	659	331	328

External Appeal Results by Type of Denial:

The overwhelming majority of external appeal requests involved denials based on medical necessity rather than denials because the service was considered experimental or investigational. There were 612 external appeal determinations involving medical necessity and only 47 external appeal determinations involving experimental or investigational treatments and clinical trials. Of the medical necessity cases reviewed, the majority involved requests for coverage of surgical services, inpatient and outpatient mental health care and inpatient hospital lengths of stays.

The following chart identifies external appeal results from July 1, 1999 through June 30, 2000 based upon whether the denial was based on medical necessity, experimental or investigational services or a clinical trial.

External Appeal Decisions by Type of Denial

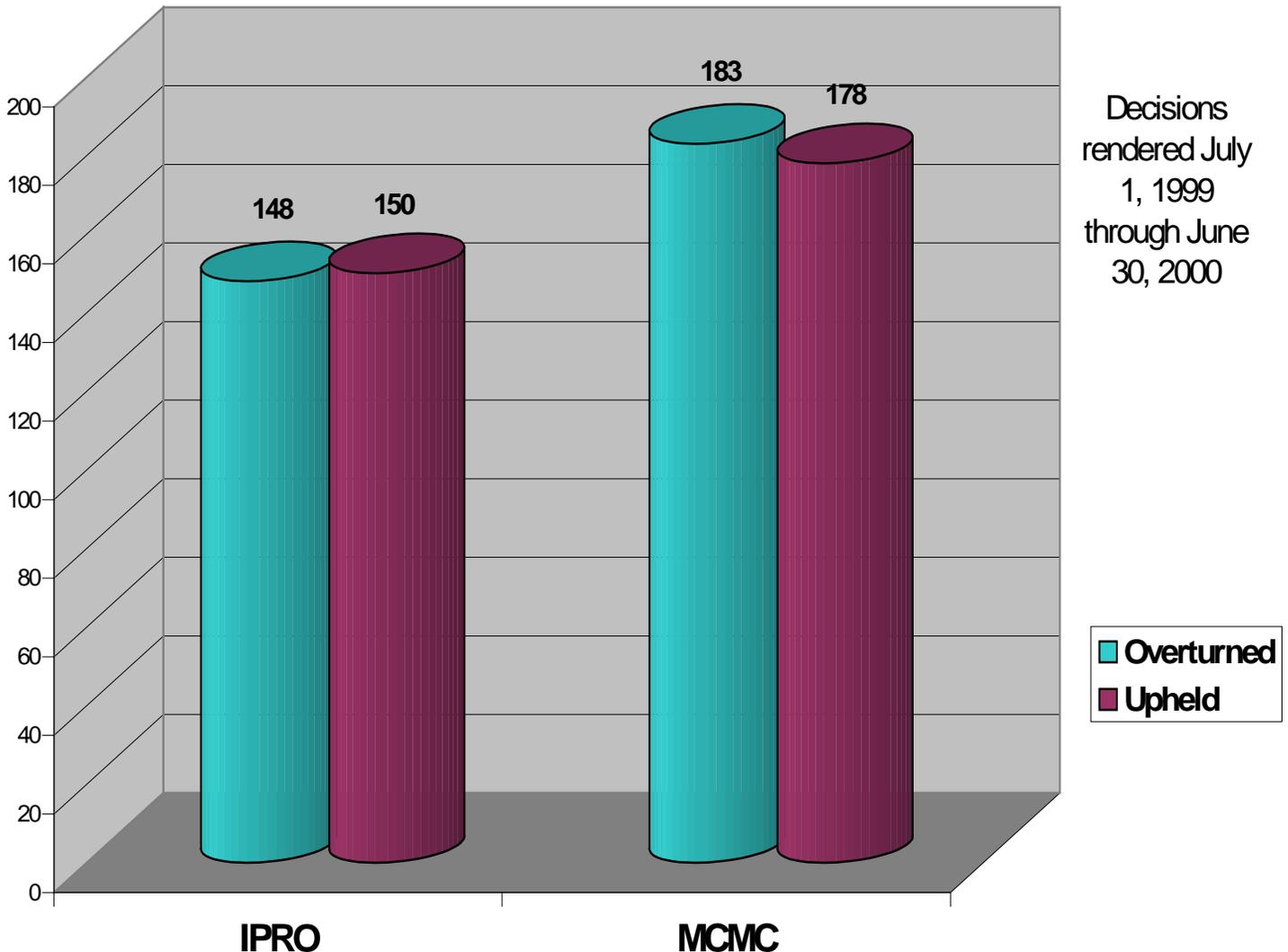


External Appeal Results by Agent:

External appeal requests are randomly assigned to agents. If the assigned agent has a conflict of interest, the appeal is assigned to another agent. Random assignment and re-assignments due to conflict of interest account for the difference in the number of appeals assigned to external appeal agents.

The overall external appeal results indicate that approximately half of the external appeal agent determinations upheld the denial of the health plan while the other half overturned the denial of the health plan. These results remain the same even when the determinations of each external appeal agent are considered respectively. IPRO upheld the determinations of health plans in 150 cases and overturned health plan denials, in whole or in part, in 148 cases. MCMC upheld the determinations of health plans in 178 cases and overturned health plan denials, in whole or in part, in 183 cases. The following chart identifies external appeal results by agent.

External Appeal Decisions by Agent



Expedited External Appeals:

The external appeal law provides that an appeal must be expedited if the patient's attending physician attests that a delay in providing the health care services would pose an imminent or serious threat to the health of the patient. When an appeal is expedited, a decision must be rendered by the external appeal agent within three days.

Insurance Department staff is on-call on weekends and holidays to handle expedited appeals submitted after close of business. Staff received and responded to 13 calls during non-business hours relating to expedited appeals from July 1, 1999 through June 30, 2000.

Month/ Year	Number of Calls
July, 1999	1
August, 1999	0
September, 1999	1
October, 1999	2
November, 1999	2
December, 1999	0
January, 2000	2
February, 2000	0
March, 2000	2
April, 2000	0
May, 2000	2
June, 2000	1

The submission and handling of expedited appeals has presented unique issues that were unanticipated when the law was implemented. Specifically, issues related to the timing of submission and the nature of expedited appeal requests have been raised.

Timing of Submission:

Insurance Department staff has identified a trend in that attending physician attestations are frequently submitted late afternoon Friday for a patient's expedited appeal. If an appeal is assigned on a Friday, the external appeal agent must render a decision by Monday. If additional information is needed, and the attending physician is not available to provide information to the agent over the weekend, it can be contrary to the best interests of the patient to assign an expedited appeal at that time because the decision must be rendered regardless of whether the information is sent. The statute does not permit flexibility with respect to the three day timeframe once an appeal is assigned to an agent.

The Insurance Department has implemented a policy of contacting the attending physician when the receipt of an expedited appeal request would result in the appeal being reviewed by an agent over the weekend to ensure that the physician will be available, if necessary, to provide information to the external appeal agent. If the physician will be not be available to provide information, Insurance Department staff discusses with the patient and the physician whether they would like the Department to wait to assign the appeal until the following business day.

Nature of Appeal:

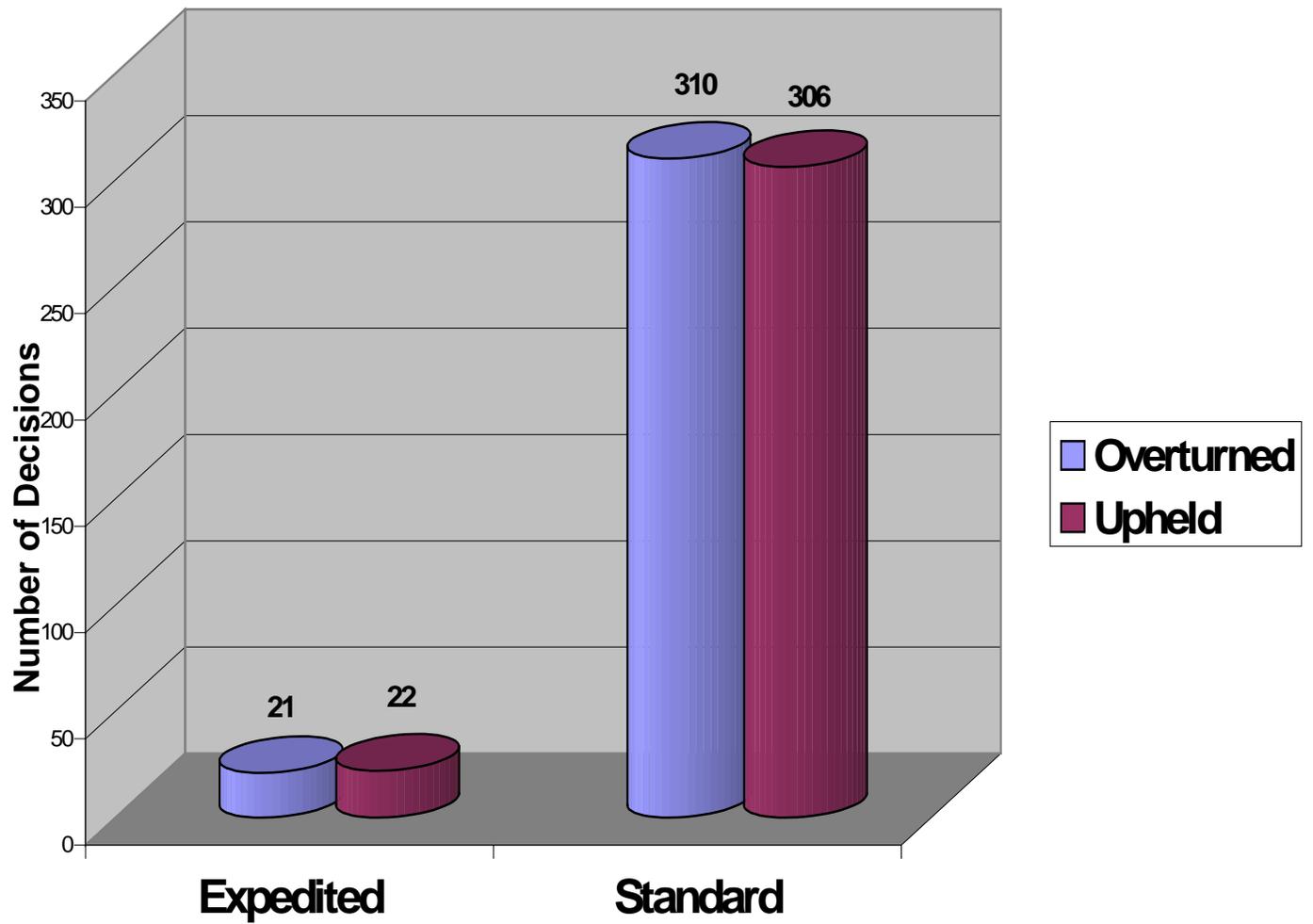
Expedited appeals have been requested by patients and attested to by attending physicians in cases where a delay would not appear to pose an imminent or serious threat to the health of the patient. Some appeals that fall into this category are submitted a month after the patient receives notice of the final adverse determination from the health plan. In other cases, expedited appeals are requested when health care services have already been provided.

If Insurance Department staff identifies an appeal that does not appear to warrant an expedited review, staff will contact the attending physician to ascertain why the physician attested that the appeal should be expedited and discuss the option of processing the appeal as standard. Processing an appeal as expedited is not always in the best interest of the patient since a decision must be rendered in three days and there is a very short timeframe to submit additional information. If the attending physician indicates that the appeal should remain expedited, it is processed as such, since the law is specific in requiring an appeal to be expedited if an attending physician attests that it should be.

The law does not, however, require an external appeal to be expedited if health care services have already been provided. In such cases the request is treated as a standard appeal.

The following chart identifies external appeal results from July 1, 1999 through June 30, 2000 based upon whether the appeal was standard or expedited.

External Appeal Decisions by Type of Appeal



Provider Appeals:

Of the 659 external appeal determinations that were rendered between July 1, 1999 and June 30, 2000, 47 involved provider appeals. The determination of the health plan was overturned, in whole or in part, in 21 cases and upheld in 26.

Questions have arisen as to when providers may request an external appeal on their own behalf. The external appeal law states that a patient, a patient's designee and, in connection with a retrospective adverse determination, a patient's health care provider shall have the right to request an external appeal.

The law specifically limits a provider's right to request an external appeal to instances when a retrospective adverse determination is rendered. Retrospective adverse determination is not specifically defined in the law, but is referenced in the portion of the law that governs a health plan's internal utilization review process and in the portion of the law that governs external appeals.¹²

Title I of Article 49 of the Insurance Law and the Public Health Law defines utilization review as the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.¹³ This definition identifies three types of utilization review (pre-authorization, concurrent review and retrospective review) and distinguishes between the three types based upon when the utilization review is conducted, not when a decision is rendered.

Title I of Article 49 of the Insurance Law and the Public Health Law provides further clarification as to what is considered concurrent review. Under the law, concurrent review includes determinations involving continued or extended health care services for a patient undergoing a course of continued treatment. A concurrent review determination must be rendered within one business day of receipt of the necessary information. Utilization review may be concurrent even if the utilization review determination is rendered after health care services have been provided, depending upon when the necessary information is received by the utilization review agent.¹⁴

¹² See Title I and Title II of Article 49 of the Insurance Law and Title I and Title II of Article 49 of the Public Health Law.

¹³ Section 4900(h) of the Insurance Law and Section 4900(8) of the Public Health Law.

¹⁴ Section 4903(c) of the Insurance Law and Section 4903(3) of the Public Health Law.

To maintain consistency with Title I of Article 49 of the Insurance Law and the Public Health Law, “retrospective adverse determination” was defined in Health Department and Insurance Department regulations to be a determination for which utilization review was initiated after health care services have been provided, and excludes initial determinations involving continued or extended health care services or additional services for a patient undergoing a course of continued treatment (concurrent review).

Providers have objected to this definition pointing out that it limits their right to request an external appeal. Representatives of provider groups have requested that the regulations be amended to include within the definition of “retrospective adverse determinations” those instances where notification of an adverse determination is received after the initiation of the disputed health care services.

The proposal put forth by providers focuses on when the utilization review determination is rendered instead of when the utilization review is conducted. With such a definition, determinations made prior to the initiation of services would remain prospective, however, any utilization review determination made after initiation would be considered retrospective. With such an interpretation, there would be no possibility for concurrent determinations. Incorporating the suggested definition would eliminate a category of utilization review and would expand a provider’s right to request an external appeal when not recognized by statute.

The Insurance Department has also received external appeal applications from providers, ineligible to request an external appeal of a concurrent utilization review denial, requesting to be considered the patient’s designee in order to file an external appeal. The Insurance Law and the Public Health Law do not define designee. However, it is the Departments’ understanding that the designee provision in the external appeal law was intended to enable the patient to designate a person to assist them in making an external appeal request in order to obtain access to health care services. It was not intended to permit disputes between providers and health plans that were not based upon a retrospective adverse determination to be subject to the external appeal process. A definition of designee was added to the regulations to ensure that a designee would have to act on behalf of a patient and could not use the external appeal process as a mechanism to arbitrate payment disputes that would not otherwise be eligible for external appeal.

The issues surrounding provider appeals raise the question as to what the legislative intent was with respect to the ability of providers to request an external appeal on their own behalf for what is essentially a payment dispute with the health plan. The Insurance Department and the Health Department have interpreted the law as enabling providers to request an external appeal on their own behalf only in limited instances.

If it is determined that the scope of provider payment disputes eligible for external review should be broadened, consideration should be given to the impact on the external appeal process which, consistent with statutory language, is currently focused on patients. In addition, consideration should be given to the costs associated with expanding the scope of provider payment disputes eligible for the external appeal process. Health plans are required to pay the cost of the external appeal regardless of whether their decision is upheld or overturned by the external appeal agent. Provider payment dispute arbitration programs typically require the party that does not prevail to pay the cost of the independent agent's review. Consideration should be given as to whether premium rates would be affected if the scope of provider payment disputes eligible for external review is broadened.

Issues Encountered and Solutions Developed:

The first year of operation of the external appeal program enabled the Insurance Department and the Health Department to identify programmatic and procedural issues not readily apparent before the law became effective. The following is a list of issues and a discussion of solutions developed.

Right to Consent to an Appeal and Release of Medical Records:

Issue:

- Issues have been raised in relation to who may request an external appeal on behalf of a patient and consent to the release of the patient's medical records in cases where the patient is incapacitated or deceased.

Solution:

- Applicable law permits parents to request an appeal and consent to the release of medical records on behalf of minor children. In such cases a parent's signature on the external appeal application is accepted.
- Applicable law also permits court appointed guardians to request an appeal and consent to the release of medical records. In such cases the signature of the guardian is accepted on the external appeal application if proof of guardianship is provided.
- If a patient is incapacitated and has a health care proxy, the signature of the designated health care agent on the external appeal application is accepted if a copy of the health care proxy is provided.
- If a patient is deceased, the signature of the executor on the external appeal application is accepted.
- The external appeal regulations were amended so that providers may obtain a patient's consent to the release of medical records and acknowledgement of the external appeal request at the time treatment is rendered, instead of having to wait until a final adverse determination is issued by the health care plan. This regulatory change addressed providers' concerns that the patient may not be available to sign the consent at the time the provider receives notification of the denial.

Decision of the External Appeal Agent:

Issue:

- There have been cases in which information is submitted by the patient or the patient's attending physician after the external appeal agent renders a determination.

Solution:

- The law does not provide for consideration of information submitted after a decision is rendered by the external appeal agent. In order to ensure that all information is submitted in a timely manner, both the Insurance Department and the external appeal agent advise the patient and provider of the timeframe in which the information must be submitted in order to be considered.

Issue:

- The Departments have received questions with respect to external appeal agent determinations and requests for reconsideration of determinations from patients, providers and health plans.
- Under the law, the decision of the external appeal agent is binding but admissible in court proceedings. There is no mechanism specified for reconsideration of determinations of external appeal agents. However, the law provides the Health Department and the Insurance Department with the authority to investigate complaints regarding requests for and the processing of external appeals.

Solution:

- Staff from the Health Department and the Insurance Department jointly review all complaints with respect to external appeal agent determinations. Staff will contact the external appeal agent for clarification in regard to the issues raised, if necessary. Staff then responds to the patient, provider or health plan.

Treatment that Must be Provided Pursuant to an External Appeal Agent's Determination:

Issue:

- Questions have been raised in relation to the scope or duration of treatment that was denied by the health plan and that must be provided when an external appeal agent overturns the health plan's denial. Specifically, health plans and patients have questioned the length of treatment or number of visits that must be covered pursuant to an external appeal agent's determination.

Solution:

- The Insurance Department and the Health Department have worked with both health plans and external appeal agents to resolve this issue. Health plan final adverse determination letters must now specify the course of treatment that has been denied. In addition, external appeal agents are required to clearly identify the course of treatment that is being approved.

Closing Remarks:

The external appeal legislation is truly remarkable in that it provides New Yorkers with critical protections that they are utilizing. Moreover, the Insurance Department, the Health Department, providers, health plans and consumer groups have worked together to implement a program that meets the needs of New Yorkers. The External Appeal Program has been working effectively and it is the mutual cooperation of these parties that has contributed to the success of the program.