

Healthcare Law Advisor

New External Appeal Law in New York

July 1999

The New York State Legislature recently passed a law permitting independent external appeals for denials of coverage by health plans. The new law took effect on July 1, 1999 and contains statutory mandates in the Insurance Law and the Public Health Law. The provisions are not applicable to a self-insured employee welfare benefit plan, as defined in the ERISA Act of 1974, or to enrollees whose only source of health services is Medicare. Emergency regulations were issued on June 18, 1999 by the New York State Department of Insurance. Following is a summary of the salient provisions of the new law.

- The external appeal process is generally a means by which enrollees, and in some instances, their health care providers, may appeal certain denials of coverage made by their health plan to an independent panel of external appeal agents certified by the State.
- An enrollee (or an enrollee's physician, in the case of a retrospective adverse determination) may make an external appeal only when a health plan makes a "final adverse determination"¹ denying requested treatment that it deems to be (1) not medically necessary or (2) experimental or investigational.
- A health plan must notify an enrollee (or an enrollee's physician, where applicable) of the right to request an external appeal upon rendering a final adverse determination. Such a notification must be in a form developed jointly by the Superintendent of Insurance and by the Commissioner of Health.
- All requests for external appeal must be submitted to and screened by the Superintendent of Insurance. All requests deemed eligible by the Superintendent will be randomly assigned to an external appeal agent.
- A **standard external appeal** is available where the enrollee has received notice from the Plan's utilization review agent of a final adverse determination. The enrollee then has **45 days** to initiate an external appeal. The external appeal agent must make a determination within **30 days** of receipt of the enrollee's request.
- An **expedited external appeal** is available if the enrollee's attending physician states that a delay in treatment would pose an imminent or serious threat to the health of the enrollee. In such case, the external appeal must be completed within **3 days** of the request.
- Under the new law, payment for external appeals shall be the responsibility of the health plan, limited only by a fee to be paid by the enrollee filing the appeal.
- In addition to creating an external appeal process, the new law changes important provisions with respect to initial utilization review determinations within the health plan. For example, prior to the new law, although health plans were subject to certain time periods in which to issue utilization review determinations, there were no consequences for failure to issue a determination within the required time period. Under the new law, a health plan which fails to issue an initial utilization review determination within the required time period is deemed to have rendered an adverse determination, which by default allows the enrollee or healthcare provider to proceed to an internal appeal.² Additionally, a failure by a health plan to make a determination on internal appeal within the requisite time period is deemed to be an approval of the service being appealed.
- Significant distinctions exist in the new law with respect to a physician's right to notification and appeal on behalf of a patient. For example, with respect to ini-

tial utilization review determinations, an enrollee's physician is entitled to notice of an initial utilization review decision where services requiring preauthorization are at issue. Further, a utilization review agent may notify the enrollee or the physician where continuing, extended, or additional healthcare services have been delivered. If the physician specifically recommended the healthcare services in question, and the utilization review agent, without discussion with the physician, renders an adverse determination, then the physician may request reconsideration of the adverse determination. In contrast, as discussed previously, a physician must be notified of the right to file and may make an external appeal on behalf of a patient only where a retrospective adverse determination has been made. Also, health plans are not required to provide physicians with a copy of the standard description of the external appeal process. Rather, physicians may request a copy of such description.

Following are two hypothetical illustrations of how the new law might apply:

- (1) A physician recommends open heart surgery for her patient, which is denied prospectively as **not medically necessary** by the health plan, in favor of angioplasty. In this case, the utilization review agent is required to give notice of such denial to both the enrollee and the physician because the services at issue require preauthorization. At this stage, the enrollee may make an **internal appeal** (i.e., within the health plan's member appeal procedures), or the enrollee and the health plan must jointly waive the right to internal appeal. If the physician believes that an expedited internal appeal is warranted,

a determination must be made within **2 business days** of receipt of the necessary information. Otherwise, the enrollee has **45 days** to file an internal appeal, and the Plan's utilization review agent must make a determination within **60 days** of receipt of the necessary information.³ If the internal appeal results in a denial, the health plan must notify the enrollee of the right to file an **external appeal**. The external appeal process as described above is implemented, with time frames of **3 days** for determination of an expedited external appeal, and **45 days** for the enrollee to file a standard external appeal and **30 days** for a determination (from the time the request is received).

- (2) A physician prescribes a cancer drug for his patient that is denied as **experimental** after the patient begins a course of treatment. Because continuing or extended healthcare services are involved, the utilization review agent must give notice to the enrollee **or** the physician of a denial within **1 business day** of receipt of the necessary information. At this point, the enrollee or physician must first go through the internal appeal process or the enrollee and health plan must jointly waive the right to internal appeal. If the enrollee is notified by the health plan of his right to an external appeal, the enrollee's attending physician must certify that his patient has a life-threatening or disabling condition for which the service would be covered but for the health plan's determination that it is experimental or investigational and (a) standard treatment has been ineffective or would be medically inappropriate or (b) there is no more beneficial treatment covered by the health plan or (c) there

exists a clinical trial. The process and time frames in illustration (1) would apply to such an external appeal.

The external appeal law and corresponding regulations present a number of challenges for providers, consumers and health plans. **Providers** will have to become aware of their role in the external appeal process, both with respect to assisting their patients in filing appeals and, in some instances, filing appeals on behalf of their patients. Correspondingly, **consumers** will need to become educated regarding their rights under the new law. Additionally, **health plans** and **providers** will have to incorporate these requirements into their contracting arrangements, coverage plans information and internal appeals policies and procedures.

If you have any questions about this *Advisor* or our health care practice, please contact: Jackie Huchenski, Chair, Healthcare Practice Group at (212) 554-7831, or Linda Abdel-Malek at (212) 554-7814.

Endnotes

¹A "final adverse determination" is defined in the external appeal regulations as an adverse determination which has been upheld by the Plan's utilization review agent following a standard or expedited internal appeal. If a health care plan offers two levels of internal appeal, a "final adverse determination" is an adverse determination made after the first internal appeal.

²The new law describes two processes for standard and expedited internal appeals, with corresponding time frames for an enrollee or a health care provider, where applicable, to make an appeal, and correspondingly, for the utilization review agent to render a determination as to such internal appeal.

³If the Plan fails to decide within 60 days, the internal appeal is deemed approved.

This Bulletin is intended as a general comment on certain recent proposed developments in the law. It does not contain a complete legal analysis or constitute an opinion of Moses & Singer LLP or any member of the Firm on the legal issues herein described. It is recommended that readers not rely on this general guide in structuring or analyzing individual transactions but that professional advice be sought in connection with any such transaction.

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