15.13 External Review – Medicaid, Medicaid Advantage Plus, Healthfirst Leaf Plans, and Commercial Plans

External Appeal

In connection with a concurrent or retrospective review, members and a member's healthcare provider are able to request an external appeal for the three (3) types of adverse determinations – **not medically necessary services, experimental or investigational, or clinical trial or treatment of rare disease or when out-of-network services are denied as not materially different from services available in-network or when services are denied because they are considered treatment for a rare disease.**

If both the member and Healthfirst agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of when the member made the agreement from the date of the denial determination. If this occurs, Healthfirst will provide a written letter with information regarding filing an external appeal to the member within twenty-four (24) hours of agreement to waive the internal appeal process.

Providers may elect an external appeal on behalf of the member within 60 days of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health (SDOH) and the State Department of Financial Services (DFS), including an application and instructions to members or providers regarding how to request an external appeal.

For Providers

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective final adverse determination within three (3) calendar days of the provider's request.

The external appeal determination decision will be made in thirty (30) days; however, more time may be needed if the external appeal reviewer needs to obtain more information (up to five [5] additional days).

The member and Healthfirst will be notified of the final determination within two (2) days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member's healthcare provider can request an expedited external appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial which is the subject of an external appeal after assignment to a certified external appeal agent but prior to assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.