# Appendix XIII-C — Standard Description and Instructions for Healthcare Consumers to Request an External Appeal

New York State Law ensures you the right to an external appeal when healthcare services are denied by your HMO or insurer (health plan) on the basis that the services are not medically necessary or that the services are experimental or still under investigation by the AMA.

To request an external appeal you must complete the application form and send it to the Department of Financial Services within
4 months of receipt of said notice of final adverse determination from your health plan in the first (1st) level of the plan's internal appeal process or within 4 months of receiving written confirmation from your health plan that the internal appeal process has been waived.
If all applicable items have not been completed, your request will not be accepted.

## What is an External Appeal?

- An external appeal is a request that you make to the State for an independent review of a denial of services by your health plan.
- Reviews are conducted by external appeal agents who are certified by the State and have a network of medical experts to review your health plan's denial of services.
- You must complete the attached application and submit the application to the Department of Financial Services to request an external appeal.

## Eligibility for an External Appeal

## To be eligible for an external appeal:

- You must have received a final adverse determination as a result of your health plan's internal utilization review appeal process or you and your health plan must have agreed to waive that appeal process. A final adverse determination is written notification from your health plan that your healthcare service has been denied through the plan's appeal process. If your health plan offers two (2) levels of internal appeals, a final adverse determination is the determination of the first (1st) level appeal.
- If you and your health plan agree to waive the internal appeal process, the health plan must confirm the agreement in writing. You must submit a request for an external appeal to the State within 4 months from receipt of a notice of final adverse determination from your health plan or within 4 months of receiving written confirmation from your health plan that the internal appeal process has been waived. If your plan had two (2) levels of internal appeals, you must file a request for external appeal within 4 months of your receipt of the notice of final determination from the plan's first (1st) level appeal process to be eligible for an external appeal.
- If services are denied as experimental, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal and your attending physician must complete the attached Attending Physician Attestation form and send the form to the Department of Financial Services.
- You may only appeal a service or procedure that is a covered benefit under your contract. The external appeal process may not be used to expand the coverage of your contract.
- Your health plan cannot be a self-insured plan. The State does not have jurisdiction over self-insured plans. Your employer can tell you if your plan is self-insured.
- The appeal cannot be for workers compensation claims or for claims under no-fault auto coverage.

## What Happens If My Health Plan Offers a Second (2nd) Level of Internal Appeal?

- You will not be required to seek a second level of internal appeal with your health plan in order to request an external appeal.
- If you seek a second level of internal appeal with your health plan, you may not have time to request an external appeal. You must request an external appeal within 45 days of receiving the determination form your health plan's first level of internal appeal.

## Am I Eligible For an External Appeal If I am Covered by Medicare or Medicaid?

- You are not eligible for this external appeal process when Medicare is your only source of health services. If you have coverage under Medicare, you must file a complaint with the Federal government for denials of services. Questions concerning Medicare coverage should be directed to the Centers for Medicare & Medicaid Services at 1-800-MEDICARE (1-800-633-4227).
- If you have coverage under Medicare and Medicaid, this external appeal process may be used solely to appeal denials of services or treatments covered by Medicaid.
- If you have Medicaid coverage you may also request a fair hearing. If you have requested an external appeal and a fair hearing,
  the determination in the fair hearing process will be the one that applies. If you have questions about the fair hearing process you should contact the New York State Department of Health at 1-800-774-4241.

## Eligibility for an Expedited (fast-tracked) External Appeal

- If your attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to your health you may request an expedited appeal. When requesting an expedited appeal, make sure you give the attending physician an attestation from your primary care doctor to complete. Your appeal will not be forwarded to the external appeal agent until your physician sends this attestation to the Department of Financial Services.

## How Long and External Appeal Will Take:

- Expedited appeals: The external appeal agent must make a determination within three (3) days of receiving your request for an external review from the State.
- Standard appeals: When your appeal is not expedited, the external appeals agent must make a determination within 30 days of receiving your request for an external review from the State. If additional information is requested, the external appeal agent has

  five (5) additional business days to make a determination.

## The Cost to you for an External Appeal

Your health plan may charge you a fee of up to $50 for an external appeal.

- If you have coverage under Medicaid, CHPlus, or your health plan determines that the fee will pose a hardship, you will not be required to pay a fee.
- If your health plan does require a fee, you must submit the fee with your application for an external appeal. If you fax your application to the Department of Financial Services, you must send the fee within three (3) business days to the Department of Financial Services. If the fee is not sent to the Department of Financial Services within this timeframe, the external appeals agent will suspend review of your appeal until payment is received.
- Only checks or money orders, made payable to your health plan, will be accepted.

- If the external appeal agent overturns your health plan's determination, the fee will be refunded to you

## When Information May be Submitted to the External Appeals Agent

- If your case is determined to be eligible for external review, you and your health plan will be notified of the certified external appeals agent assigned to review your case.
- Your health plan must send your medical and treatment records to the external appeal agent.our health plan must send your medical and treatment records to the external appeal agent.
- When the external appeals agent reviews your case, the agent may request additional information from you or your doctor.
  This information should be sent to the external appeals agent immediately.
- You and your doctor can submit information even when the external appeals agent has not requested specific information.
  You must submit this information within 45 days from when your health plan made a final adverse determination or from when you and your health plan agreed to waive the internal appeal process.

*** It is important to send this information immediately. Once the external appeals agent makes a determination or once your 45 days time period ends, you will be unable to submit additional information.

## What Happens When an External Appeals Agent Makes a Decision?

- **Expedited appeals:** If your appeal was expedited, you and your health plan will be notified immediately by telephone or fax of the external appeal agent's decision. Written notification will follow.
- **Standard appealstandard appeals:** If your appeal was not expedited, you and your health plan will be notified in writing within two business days of the external appeals agent's decision.
- The decision of the external appeals agent is binding on you and your health plan.

If you have any questions, please contact the Department of Financial Services at: **1-800-400-8882** or the New York State Department of Health at **1-800-774-4241** or visit **http://www.dfs.ny.gov/insurance** or **www.health.state.ny.us.**