5.8 Provider External Appeals – Effective January 1, 2010

Provider External Appeal Rights

Public Health Law 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. A provider will be responsible for the full cost of an external appeal for a concurrent adverse determination upheld in favor of Senior Health Partners; Senior Health Partners is responsible for the full cost of an appeal that is overturned; and the provider and Senior Health Partners must evenly divide the cost of a concurrent adverse determination that is overturned in part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of the MCO. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application (see Attached External Appeals Application and Instructions) and the standard designation forms delivered by the State. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.

Hold Harmless

Public Health Law was amended to add a new section 4917. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable copays, from a member for services determined to be not medically necessary by the external appeal agent. Thus, members are held harmless in such cases.

New York State External Appeal Application

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or out-of-network, complete and send this application to the above address within 45 days of the plan's final adverse determination. For help call 1-800-400-8882.

1. **Applicant Name:**

_____

(Please check one) [ ]Insured/Patient [ ]Patient's Designee [ ]Provider

2. **Patient Name:**

_____

3. Patient Address:

_____

_____

4. **Patient Phone Number:**

Home(_____)_____Work(_____)_____

5. **Patient E-mail (if you want contact by e-mail):** _____

6. **Health Plan Name:**

_____

7. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing

through Medicaid or received a fair hearing determination?

Yes _____ No_____

8. **Reason for Health Plan Denial: (Please check one.)**

[ ] Not medically necessary. [ ] Experimental / investigational.

[ ] Clinical trial. [ ] The treatment is for a rare disease.

[ ] Out-of-network and the health plan proposed an alternate in-network service.

9. Describe the service and the date(s) of service. **Attach the final adverse determination from the first level of appeal with the health plan, or the health plan's letter waiving the appeal,** along with any other information you would like considered.

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

10. If the patient has not received the service, the appeal may be expedited if the patient's physician fills out the attached form stating a delay will seriously threaten the patient's health. An expedited decision will be made in 3 days instead of 30 days, even if the patient or the patient's physician do not provide needed medical information to the external appeal agent.

Is this a request for an expedited appeal? [ ] Yes No [ ]

11. If this is a request for an **expedited appeal,** an appeal of **experimental / investigational services**, a **clinical trial denial**, an **out-of-network denial**, or a **rare disease treatment,** the patient must give the attached Physician Attestation (pages 3-5) to the physician who prescribed the treatment. (See special rules for rare diseases on page 3.) The physician must complete the form and send it to the Insurance Department. (Please check one.)

[ ] I gave the form to my physician [ ] I did not give the form to my physician.

12. **External Appeal Fee:** You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you. (Please check one.)

[ ] I enclosed a check or money order made out to the health plan.

[ ] I faxed my application and will mail the fee to the Insurance Department within 3 days.

[ ] The patient is covered under Medicaid, Child Health Plus or Family Health Plus and no fee is charged.

[ ] The patient requests a fee waiver for hardship and the patient will provide documentation to the health plan.

[ ] The health plan does not charge a fee for an external appeal / the fee is not required.

13. **I am sending this application to the Insurance Department by:** (Please check one.)

[ ] Certified or registered mail to New York State Insurance Department, PO Box 7209, Albany, NY 12224-0209.

[ ] Fax to **1-800-332-2729.** If your appeal is expedited, you must also call toll free 1-888-990-3991 to tell us.

14. **Name of the Patient's Physician / Provider:** _____

Address: _____
_____

Phone Number: (_____)_____

Fax Number: (_____)_____

15. **Complete this only if a designee submits this external appeal on the patient's behalf.** The patient is under no obligation to request an appeal and may be asked to confirm that a designee was authorized.

Name of Designee: _____

Relationship to Patient: _____

Address: _____

Phone Number: (_____)_____

Fax Number: (_____)_____

Designee E-mail (if you want contact by e-mail): _____

16. The patient must sign and date this external appeal request and consent to the release of medical records. An external appeal agent assigned by the New York State Insurance Department will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I, _____ hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related, mental health, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on my appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Insurance Department in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

_____

Signature of Patient

_____

(Date)

(Or the patient's representative who can consent to the release of the patient's medical records. If a parent

signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

Patient's Health Plan ID#:_____

17. Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. **This item should only be completed by providers appealing on their own behalf, or as the patient's designee.** The health plan's initial denial and final adverse determination from the first level of appeal must be attached. I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, the $50.00 fee is not required; however, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Name: _____

Provider Contact Person: _____

Phone Number:(_____)_____

Provider E-mail (if you want contact by e-mail): _____

Provider Signature:_____

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.

- For an **experimental / investigational** denial, the patient's physician must complete items **1-12 and 16**.
- For a **clinical trial** denial, the patient's physician must complete items **1-10, 13 and 16**.
- For an **out-of-network** denial, the patient's physician must complete items **1-9, 12 and 16**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 14 and 16**.
- For an **expedited appeal**, the patient's physician must complete items **1-9, 15 and 16**.

You must mail this attestation to the above address or fax it to 1-800-332-2729. The Insurance Department or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately. If you have any questions call 1-800-400-8882.

1. **Name of Physician completing this form:**

_____

To appeal an experimental / investigational, clinical trial, or out-of-network denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient's treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.

2**. Physician Address:**

_____

3. **Contact Person:** _____

4. **Phone Number: (_____)**_____

Fax Number: (_____)_____

5. **Physician E-mail (if you want contact by e-mail):** _____

6. **Name of Patient:** _____

7. **Patient Address:** _____

8. **Patient Phone Number:**

_____

9. **Patient Health Plan Name and ID Number:**

_____

10. **Complete this item for an external appeal of an experimental / investigational denial or a clinical trial denial. DO NOT complete this item for an appeal of an out-of-network denial or a rare disease denial**. As the patient's physician, I attest: (Select a or b without altering.)

a. ___ The patient has a life-threatening condition or disease with a high probability of causing the patient's death.

OR

b. ___ The patient has a disabling condition or disease which renders the patient unable to engage in any substantial gainful activities by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has or can be expected to last for a continuous period of not less than 12 months; or who, in the case of a child under the age of 18, suffers from any medically determinable physical or mental impairment of comparable severity.

11. **Complete this item for an external appeal of an experimental / investigational denial. DO NOT complete this item for an appeal of a patient's clinical trial participation, an out-of-network denial, or a rare disease denial.** As the patient's physician, I attest: (Select a or b without altering.)

a. ___ Standard health services or procedures have been ineffective or would be medically inappropriate.

OR

b. ___ There does not exist a more beneficial standard health service or procedure covered by the health plan.

12. **Complete this item for an external appeal of an experimental / investigational denial or an out-of-network denial. DO NOT complete this item for an appeal of a patient's clinical trial participation or rare disease.**

For an experimental / investigational denial: As the patient's physician I attest that I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service. (Complete a and b below.)

For an out-of-network denial: As the patient's physician I attest that the out-of-network health service (identify service)

_____

_____

_____

is materially different from the alternate in-network health service recommended by the health plan, and based on the following two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. **(Complete a and b below.)**

a. List the documents relied upon in the space below and **attach a copy of the documents.**

Document #1 Title:_____

Publication Name: _____

Issue Number : _____ Date: _____

Document #2 Title: _____

Publication Name: _____

Issue Number :_____ Date: _____

b. The medical and scientific evidence listed above meets one of the following criteria *(note peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer):* (**Check the applicable items below for each of the documents**.)

[ ] Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed abstracts accepted for presentation at major medical association meetings;

Document #1 [ ] Document #2 [ ]

[ ] Medical journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Federal Social Security Act;

Document #1 [ ] Document #2 [ ]

[ ] The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the American Medical Association Drug Evaluation; (iii) the American Dental Association Accepted Dental Therapeutics; and (iv) the United States Pharmacopeia-Drug Information;

Document #1 [ ] Document #2 [ ]

[ ] Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Document #1 [ ] Document #2 [ ]

13. **Complete this item only for a denial of a patient's participation in a clinical trial.**

a. ___ There exists a clinical trial which is open, the patient is eligible to participate, and the patient has or will likely be accepted. (**Although not required, it is recommended you enclose the clinical trial protocols and related information.**)

The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

14. **Complete this item only for a rare disease denial.**

As a physician other than the patient's treating physician, I attest the patient has a rare life-threatening or disabling condition or disease. There is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service, the requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service. I **do**____ **do not**____ (**check one**) have a material financial or professional relationship with the provider of the service **AND**: (Select a or b without altering.)

a. ___ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.

OR

b.___ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

* If provision of the service requires approval of an Institutional Review Board include the approval with this attestation.

15. **Complete this item only for an expedited appeal.**

If the patient has **not yet received the treatment**, and a **delay would pose an imminent or serious threat to the patient's health**, the patient's physician may request the appeal to be expedited. The external appeal agent must make an expedited decision in 3 days, instead of 30 days, regardless of whether you provide all necessary medical information or records to the agent. **You must send any information to the agent immediately in order for it to be considered. (Please check one.)**

___**YES**, this appeal must be expedited. I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 3 days of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.

During non-business days I can be reached at: _____

___**NO,** this appeal does not need to be expedited.

16. **Complete this item for an external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.**

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Physician Name (Please Print Clearly):

_____

Signature of Physician **(Date)**

EXTERNAL APPEAL INSTRUCTIONS & APPLICATION

Consumers have the right to an external appeal when health care services are denied by an HMO or insurer (health plan) as not medically necessary, experimental/ investigational, a clinical trial, a rare disease treatment, or out-of-network. Providers have their own right to an external appeal when these health care services are denied concurrently or retrospectively. To request an external appeal, complete the attached application and send it to the New York State Insurance Department within 45 days of the date of the health plan's final adverse determination.

What Is An External Appeal? It is a request you make to the New York State Insurance Department when a health plan denies health care services. Your appeal will be reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or part), or uphold the health plan's denial.

When Do I Request An External Appeal? You must send an external appeal application to the Insurance Department within 45 days from the date of the final adverse determination from the first level of appeal with the health plan OR the health plan's letter waiving the internal appeal process. If your application is not sent to the Insurance Department within 45 days (with an additional 8 days allowed for mailing), you will not be eligible for an external appeal.

What If A Health Plan Offers A Second Level Of Internal Appeal? You do not have to request a second level of internal appeal. However, if you request a second-level internal appeal, you must still request an external appeal within 45 days of the health plan's first level appeal determination.

What If Services Are Denied As Experimental / Investigational, A Clinical Trial, Or A Rare Disease? The patient must have a life-threatening or disabling condition or disease and the patient's physician (who for rare diseases may not be the treating physician) must complete and send pages 3-5 of the application to the Insurance Department.

What If Services Are Denied As Out-Of-Network? The patient must be covered under an HMO or managed care insurance contract and a pre-authorization request must be denied because the requested service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service. The patient's physician must complete and send pages 3-5 of the application to the Insurance Department.

When Will An External Appeal Agent Make A Decision? In 3 days for expedited appeals or 30 days for standard appeals. The external appeal agent's decision is binding on the patient and the patient's health plan.

How Do I Request An Expedited (fast-tracked) External Appeal? The patient's physician must complete pages 3-5 of the application and attest that the patient has not received the treatment and a delay would pose a serious threat to the patient's health. Once an appeal is expedited, a decision will be made in 3 days, even if all of the patient's medical information has not been submitted.

When Can I Send Information To The External Appeal Agent? The patient, the patient's designee, and where appropriate the patient's provider, will be notified when an external appeal agent is assigned to the appeal.You must send any information to the agent immediately. Once the agent makes a decision, additional information will not be considered.

Do I Pay A Fee For An External Appeal? Some health plans charge $50.00, which is waived for patients who appeal and are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship to the patient. The fee will be returned to you if the external appeal agent overturns the health plan's denial.

What If A Patient Has Medicare Or Medicaid Coverage? Patients covered under Medicare are not eligible for an external appeal and should call 1-800-MEDICARE or visit www.medicare.gov. Patients covered under

regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call 1-800-342-3334 or visit www.otda.state.ny.us/oah for fair hearing information.

What Are My External Appeal Rights If I Am A Health Care Provider? You have your own right to an external appeal of a concurrent or retrospective final adverse determination. Regardless of whether you appeal on your own behalf, or as the patient's designee, you may not pursue reimbursement from the patient for the health care service if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance, or deductible.

FOR QUESTIONS OR HELP WITH AN APPLICATION CALL THE NEW YORK STATE INSURANCE DEPARTMENT AT 1-800-400-8882 OR VISIT http://www.dfs.ny.gov/insurance/extapp/extappl.pdf