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External Appeals - Frequently Asked Questions, Instructions, and Applications

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, in certain cases, as out-of-network**. Providers have their own right to an external appeal when these health care services are denied concurrently or retrospectively. External appeal requests must be submitted to the New York State Department of Financial Services and the Department will assign independent medical experts to review the appeal.

NOTE: The External Appeal Application referenced below is in **PDF format**.

Consumer External Appeal Rights

- To request an external appeal, you must complete the **New York State External Appeal Application** and send it to the New York State Department of Financial Services. The external appeal application is in PDF format.
- Consumers should read the **External Appeal Instruction**s for answers to frequently asked questions and for assistance in completing an external appeal application.
- If you still have questions about your external appeal rights after reading the external appeal instructions, check **More Frequently Asked Questions**.
- The Department of Financial Services is available to provide any assistance you may need in requesting an external appeal. We can be reached at 1-800-400-8882 or by e-mail at: **Externalappealquestions@dfs.ny.gov**.

Provider External Appeal Rights

- Health care providers may request an external appeal on their own behalf to obtain payment when a health plan makes a concurrent or retrospective adverse determination denying health care services as not medically necessary, experimental / investigational, a clinical trial or a rare disease treatment. To request an external appeal, providers must complete the **New York State External Appeal Application**.
- Providers should read the **External Appeal Instruction**s for answers to frequently asked questions and for assistance in completing an external appeal application.
- If you still have questions about your external appeal rights as a health care provider, check **External Appeal Information For Health Care Providers**.

External Appeal Agent Information

- External appeal cases are assigned to external appeal agents that are certified by the New York State Department of Financial Services and Health Department and have a network of medical experts available to review a health plan's denial. For information on New York's certified external appeal agents, **select this link**.

External Appeal Law, Regulation and Annual Report

- NOTE: The documents linked to in this section are in PDF format.
- For the external appeal law, codified in Title I & II of Article 49 of the Insurance Law and Title I & II of Article 49 of the Public Health Law, **select this link**.
- For the current External Appeal Regulation, 11 NYCRR 410 (Regulation 166), **select this link**.
- For the External Appeal Annual Report, **select this link**.

External Appeal Instructions & Application

Consumers have a right to an external appeal when their HMO or insurer (health plan) denies health care services as not **medically necessary (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), experimental / investigational (including a clinical trial or rare disease treatment) or, in certain cases, out-of-network**. To request an external appeal, consumers or their designees must complete the attached application and send it to the New York State Department of Financial Services **within 4 months** of the date of the health plan's final adverse determination. Providers have their own right to an external appeal when health care services are denied concurrently or retrospectively, and must request an external appeal within 45 days.

What Is An External Appeal? It is a request you make to the Department of Financial Services 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? Consumers or their designees must send an external appeal application to the Department of Financial Services **within 4 months** from the date of the **final adverse determination from the first level of appeal** with the health plan **OR** the waiver of the internal appeal process. Providers appealing on their own behalf must request an external appeal within 45 days of the final adverse determination. **If you do not send your application to the Department of Financial Services within the required timeframe** (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 Internal Appeal? You do not have to request a second-level internal appeal. However, if you request a second-level internal appeal, you must still request an external appeal within 4 months (or 45 days for provider appeals) of the health plan's first level appeal determination.

What If Services Are Denied As Experimental / Investigational (including a Clinical Trial or Rare Disease)? The patient's physician (for rare diseases cannot be the treating physician) must complete and send pages 4-6 of the application to the Department of Financial Services.

What If Services Are Denied As Out-Of-Network? The patient must have an HMO or managed care insurance contract and a pre-authorization request must be denied because the 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 4-6 of the application to the Department of Financial Services.

When Will An External Appeal Agent Make A Decision? Within **72 hours** 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 denial must concern an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized; or the patient's physician must complete pages 4-6 of the application and attest that the patient has not received the treatment and a 30 day timeframe would seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health. The patient may request an expedited internal and external appeal at the same time. Once an external appeal is expedited, a decision will be made in 72 hours, even if all the patient's medical information has not been submitted.

When Can I Send Information To The External Appeal Agent? You will be notified when an external appeal agent is assigned. 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? Health plans may charge a $25.00 fee to patients or their designees, not to exceed $75.00 in a single plan year. The fee 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. Health plans may charge providers a $50.00 fee per appeal. 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 a NYS 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.

FOR QUESTIONS OR HELP WITH AN APPLICATION
CALL THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES AT 1-800-400-8882,
E-MAIL US at externalappealquestions@dfs.ny.gov OR VISIT OUR WEBSITE at www.dfs.ny.gov

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More Frequently Asked Questions

What Should I Do When My Health Plan Denies Services?

You will first need to appeal the denial with your health plan within the timeframe required by your health plan (typically either 45 days or 180 days).

When Will My Health Plan Decide My Appeal?

If you have coverage through your employer, your health plan must typically make a determination within:

- The earlier of 2 business days of receiving all necessary information or 72 hours of receiving your appeal, for expedited appeals.
- 2 business days of receiving all necessary information for appeals of continued or extended health care services if you are undergoing a course of continued treatment.
- 30 days of receiving your appeal request if you appealed a pre-authorization of service denial (unless your health plan has two levels of internal appeal and then a decision must be made within 15 days).
- 60 days of receiving your appeal request for all other appeals (unless your health plan has two levels of internal appeal and then a decision must be made within 30 days).

If you have any other type of group coverage, or direct payment coverage, your health plan must make a determination on your appeal within:

- 2 business days of receiving all necessary information for expedited appeals, or appeals of continued or extended health care

services if you are undergoing a course of continued treatment.

- 60 days of receiving the necessary information for all other appeals.

What If My Health Plan Does Not Make A Timely Decision On My Internal Appeal?

If your health plan does not make a determination within 2 business days of receiving all necessary information for expedited or continued treatment appeals, or within 60 days of receiving the necessary information for all other appeals, the adverse determination is reversed, and the health care service must be provided. No external appeal is necessary.

My Health Plan Offers Two Levels Of Internal Appeal. Must I File A Second Appeal With My Health Plan Before Requesting An External Appeal?

No. Your health plan may not require you to exhaust a second level of internal appeal to be eligible for an external appeal. In fact, the 45-day time limit to file an external appeal begins upon receipt of the final adverse determination from the first-level appeal with your health plan. So by choosing a second-level appeal with your health plan, the time may expire for you to request an external appeal.

Since The Timeframe To Request an External Appeal is 45 Days From When I Received The Determination From The First Level Of Appeal With My Health Plan, How Will The Department of Financial Services Know When I Received The Determination?

It will be presumed that you received the final adverse determination within 8 days of the date on the determination, so that you will have 53 days (45 + 8) from the date on the final adverse determination to request an external appeal.

You will not be provided additional time if you do not pick up your mail from a Post Office Box, or if you are away from home.It will still be presumed that you received the final adverse determination within 8 days of the date on the determination.

Who Should Sign Page 3 Of The External Appeal Application?

The patient must sign page 3 of the **external appeal application**.

If the patient is a minor, a parent or guardian may sign the **external appeal application**. If a guardian signs the application, proof of guardianship must be submitted.

If the patient is incapacitated, a guardian may sign the **external appeal application** and proof of guardianship must be submitted.

If the patient is deceased, the executor or administrator of the patient's estate may sign the **external appeal application** and proof that the person is the executor or administrator must be submitted.

Am I Eligible For An External Appeal If My Health Plan Denies Coverage Because I Requested Services From A Non-Participating Provider?

Yes, if you are covered under an HMO or managed care insurance contract and a pre-authorization request is denied because your health plan is unable to provide the requested service in-network and your health plan recommends an alternate in-network service that your health plan believes is not materially different from the out-of-network service.

No, if the out-of-network service is available in-network, even if an out-of-network provider has more experience in diagnosing or treating your condition.

Am I Eligible For An External Appeal If I Have Health Insurance Through My Employer Who Is Self-Insured?

No. Federal law, not New York State law, applies to self-insured coverage because an employer and not an insurer or HMO assumes the risk for the coverage. Check with your employer to find out if your coverage is self-insured. If you have questions or concerns in relation to your self-insured coverage, contact the U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW, Washington DC, 20210.

Am I Eligible For An External Appeal If My Health Plan Denies Coverage Because I Have A Pre-Existing Condition Or Because I Exhausted a Benefit Under My Health Insurance Contract?

No. Only medical necessity, experimental / investigational, clinical trial, rare disease treatment, or certain out-of-network denials are eligible for external appeal.

If your health plan denies coverage for any other reason, you will not have a right to an external appeal, but you will likely have appeal rights with your plan. Check your member handbook and subscriber contract for information on how to appeal a denial with your health plan.

In addition, the Department of Financial Services's Consumer Assistance Unit is available to investigate any complaint you may have against your health plan. You can submit your complaint to the Department of Financial Services's Consumer Assistance Unit using our **Online Consumer Complaint Form** located on this Web site. For more information on how to file a consumer complaint, call 1-800-342-3736.

If I Am Unable To Fully Complete An External Appeal Application, Will I Still Be Eligible For An External Appeal?

You must send whatever you are able to complete to the Department of Financial Services. The Department of Financial Services will work with you to try and complete your application. However, if you do not respond to the Department of Financial Services's requests for information, your external appeal application will be rejected.

If I Am Requesting An External Appeal For An Experimental / Investigational Treatment, Clinical Trial, Rare Disease Treatment, Or An Out-Of-Network Service Should I Wait For My Physician To Complete The Physician Attestation Before I Send My Application To The Department of Financial Services?

No. You should send your **application** to the Department of Financial Services as soon as possible so you do not miss the 45 day external appeal timeframe. If your physician does not submit the physician attestation, the Department of Financial Services will contact you and your physician to notify you that the physician attestation must be completed.

What Does My Physician Need To Do If I Am Requesting An External Appeal For An Experimental / Investigational Treatment?

Your physician must complete the physician attestation on pages 4 - 6 of your **external appeal application** and attest that you have a life-threatening or disabling condition or disease.

Your physician must attest that standard health services have either been ineffective or would be medically inappropriate, or that there does not exist a more beneficial standard health service.

Your physician must submit two documents of medical evidence, for example, articles from medical journals, that the proposed treatment is likely to be more beneficial than any standard treatment.

What Does My Physician Need To Do If I Am Requesting An External Appeal For A Clinical Trial?

Your physician must complete the physician attestation on pages 4 - 6 of your **external appeal application** and attest that you have a life-threatening or disabling condition or disease.

Your physician must attest that there exists a clinical trial which is open, that you are eligible to participate and that you have or will likely be accepted in the clinical trial.

Your physician does not need to include two documents of medical evidence; however, it is recommended that your physician include the clinical trial protocols.

What Does My Physician Need to Do If I Am Requesting An External Appeal For An Out-Of-Network Denial?

Your physician must complete the physician attestation on pages 4 - 6 of your **external appeal application** and attest that the out-of-network health service is materially different from the alternate in-network health service your health plan recommended.

Your physician must submit two documents of medical evidence, for example, articles from medical journals, that the proposed out-of-network health service is likely to be more clinically beneficial than the alternate in-network treatment and for which the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

What Does A Physician Need to Do If I Am Requesting An External Appeal For A Rare Disease Treatment?

A physician, other than your treating physician, must complete the physician attestation on pages 4 - 6 of your **external appeal application** and attest that you have a rare life-threatening or disabling condition or disease that either has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or affects fewer than 200,000 United States residents per year.

The physician must also attest that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, that the requested service is likely to benefit you in the treatment of your rare disease, and that such benefit outweighs the risk of the service.

The physician does not need to include two documents of medical evidence; however, if provision of the service requires approval of an Institutional Board, the approval must be included with the attestation.

Who Will Review My External Appeal?

The Department of Financial Services screens external appeal requests for eligibility and completeness and assigns eligible requests to external appeal agents for review.

External appeal agents are certified by the New York State Department of Financial Services and the New York State Health Department.

External appeal agents have networks of medical experts available to review appeals. External appeal agents must assign one clinical peer to review appeals of medical necessity denials. Three clinical peers are assigned to review appeals of experimental / investigational denials, clinical trial denials and rare disease denials. Up to three clinical peers are assigned to review appeals of out-of-network denials.

Clinical peers are experienced physicians or other health care professionals who are in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal.

What Information Does The External Appeal Agent Consider When Reviewing An Appeal?

The external appeal agent will review your external appeal application, the materials you submit with your application, your medical records, any attestation submitted by your physician, articles submitted by your physician, any other information submitted by your physician or health care provider, the clinical standards of your health plan, and generally accepted practice guidelines.

How Does The External Appeal Agent Get My Medical Records And Treatment Information?

The external appeal agent will send a request for information to you, your health plan, and your physician / health care provider. Your health plan is required to send your medical records to the external appeal agent. However, there may be times when your health plan does not have your complete medical record but your physician / health care provider does. It is important that you work with your physician / health care provider to make sure that the medical records and treatment information your physician / health care provider has will be sent to the external appeal agent. An external appeal agent is required to make a decision on your appeal even if all your records are not submitted.

What Standard Will The External Appeal Agent Use When Reviewing An Appeal?

For medical necessity appeals, the external appeal agent will make a determination as to whether a health plan acted reasonably, with sound medical judgment, in the best interest of the patient.

For experimental / investigational treatment appeals, the external appeal agent will make a determination as to whether the proposed health service is likely to be more beneficial than any standard treatment or treatments for a patient's life-threatening or disabling condition or disease.

For clinical trial appeals, the external appeal agent will make a determination as to whether the clinical trial is likely to benefit the patient in the treatment of the patient's condition or disease.

For rare disease treatment appeals, the external appeal agent will make a determination as to whether the requested health service is likely to benefit the patient in the treatment of the patient's rare disease and that such benefit to the patient outweighs the risks of such health service.

For out-of-network appeals, the external appeal agent will assign one clinical peer to make a determination as to whether the out-of-network service is materially different from the alternate recommended in-network service.If the clinical peer determines that the out-of-network service is not materially different, your health plan's denial will be upheld.If the clinical peer determines that the out-of-network service is materially different from the in-network service, the external appeal agent will assign two additional peer reviewers to the panel to make a determination as to whether the out-of-network health service is likely to be more clinically beneficial than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

Does My Health Plan Have To Follow The Decision Of The External Appeal Agent?

Yes. External appeal decisions are binding. Call the New York State Department of Financial Services's hotline at 1-800-400-8882 if your HMO or insurer is not complying with an external appeal agent's determination.

I Am Due Payments From My Health Plan As A Result Of An External Appeal. When Can I Expect To Be Paid?

You should receive payment from your health plan within 45 days of the date the plan was notified of the external appeal agent's determination, provided that the claim meets the requirements of law.

If payments are not made within the 45-day period, you are entitled to interest payments.

Will Requesting An External Appeal Impact Any Rights I May Have To Pursue A Legal Action Against My Health Plan?

No. The decision of the external appeal agent is binding, but admissible in a court proceeding.

Where Can I Get An External Appeal Application?

Your health plan must send you an external appeal application with any final adverse determination from a first level of appeal when services are denied as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or in certain cases as out-of-network.

You can also request a copy of an external appeal application from your health plan at any time or you can call the Department of Financial Services at 1-800-400-8882 or via e-mail at: **Externalappealquestions@dfs.ny.gov** to obtain a copy. To download a copy of the external appeal application, **select this link**.

Where Do I Send My External Appeal Application?

You must send your external appeal application to the Department of Financial Services at PO Box 7209, Albany, NY 12224-0209.

What If I Have Questions Or Need Help Completing An External Appeal Application?

Call the Department of Financial Services's hotline at 1-800-400-8882 or e-mail the Department at: **Externalappealquestions@dfs.ny.gov**. Staff from the Department's Consumer Assistance Unit is available from 9:00 a.m. – 5:00 p.m. Monday through Friday to answer your external appeal questions.

If you need help with an expedited appeal on a weekend or holiday, call 1-888-990-3991.

Who Pays The External Appeal Agent's Fee?

The health plan pays the cost of the external appeal for appeals submitted by consumers. Some health plans will charge you a $50.00 fee to help cover this cost, which is waived if you are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship to you. Also, the fee will be returned to you if the external appeal agent overturns the health plan's denial in whole or in part.

Where Can I Get A Copy Of The External Appeal Law And Regulations?

For the external appeal law, codified in Title I & II of Article 49 of the Insurance Law and Title I & II of Article 49 of the Public Health Law, **select this link**.

For the current external appeal regulation, 11 NYCRR 410 (Regulation 166), **select this link**.

Where Can I Get A Copy Of The External Appeal Annual Report?

For the current external appeal annual report, **select this link**.

External Appeal Information for Health Care Providers

When May I Request My Own External Appeal As A Provider?

Prior to January 1, 2010, health care providers had an independent right to appeal only **retrospective adverse determinations**. Beginning January 1, 2010, health care providers have an independent right to also appeal **concurrent adverse determinations**.

What Is A Concurrent Adverse Determination?

A concurrent adverse determination is a determination involving continued or extended health care services, or additional services for a patient undergoing a course of continued treatment.

What Is A Retrospective Adverse Determination?

A retrospective adverse determination is a determination for which utilization review was initiated after health care services have been provided. Retrospective adverse determination does not mean a pre-authorization determination or an initial determination involving continued or extended health care services, or additional services for a patient undergoing a course of continued treatment.

Who Pays The External Appeal Agent's Fee?

For provider appeals of **retrospective adverse determinations**, the health plan will pay the cost of the external appeal. Some health plans will charge providers a $50.00 fee to help cover the cost, which will be returned to the provider if the external appeal agent overturns the health plan's denial in whole or part.

For provider appeals of **concurrent adverse determinations**, the health plan will pay the cost of the external appeal if the plan's denial is overturned; the provider will pay the cost of the external appeal if the plan's denial is upheld; and the health plan and the provider will split the cost of the appeal if the plan's denial is overturned in part. The $50 fee is not required in these cases, and the provider must pay the external appeal agent within 45 days of receipt of the external appeal decision.

May I Request An External Appeal As My Patient's Designee?

Yes. You need to complete the designee information in item 14 of the external appeal application. The Department of Financial Services may contact your patient to confirm the designation. If we do not receive a response from your patient after two written requests, and the denial is concurrent or retrospective, we will contact you and give you the option to pursue the appeal on your own behalf.

If a health care provider submits an appeal acting as the patient's designee, the health plan will be responsible for the payment of the external appeal agent's fee.

If your patient asks you to complete the Physician Attestation for the patient's appeal of an experimental / investigational treatment, clinical trial, rare disease treatment, out-of-network service, or for the patient's expedited appeal, you do not need to be the patient's designee and you do not need to complete the designee information in item 14 of the external appeal application.

When Should I Submit Medical And Treatment Information To The External Appeal Agent?

An external appeal agent will contact you to request the patient's medical records and treatment information. This information must be sent to an external appeal agent immediately for expedited appeals. For standard appeals, it is recommended that you submit the information within three business days. External appeal agents must render a standard appeal decision within 30 days, but may make the decision sooner. Information submitted after the external appeal agent renders a determination may not be considered by the agent.

When Am I Prohibited From Balance Billing My Patient For The Health Care Service?

If you request an external appeal of a concurrent denial, including when you request the appeal as your patient's designee, you are prohibited from pursuing reimbursement from your patient for services determined not medically necessary by the external appeal agent, except to collect a copayment, coinsurance or deductible.

You should also check your provider contract because contracts typically prohibit providers participating with HMOs and insurers from balance billing their patients.

External Appeal Agent Information

Independent Medical Expert Consulting Services

Independent Medical Expert Consulting Services, Inc. (IMEDECS, formerly known as HAYES Plus, Inc.), located in Lansdale Pennsylvania, was certified on June 21, 2001 as an external appeal agent to conduct external reviews in New York. IMEDECS is a nationally accredited independent review organization. The IMEDECS clinical peer network is comprised of experienced board certified physicians and other health care providers qualified to review the patient-specific clinical circumstances of each case. IMEDECS is dedicated to quality health

care and improved clinical outcomes. The IMEDECS mission is to provide unbiased, informed expert medical reviews using the latest published scientific evidence and widely accepted practice guidelines. You may visit the IMEDECS website at **www.imedecs.com**.

Island Peer Review Organization

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 an extensive network of clinical peer reviewers, including board certified physicians and other health care professionals, with the expertise to provide a full range of external reviews. IPRO provides ongoing in-service training and re-training for clinical peer reviewers to ensure the optimal level of skill. You may visit IPRO's web site at **www.ipro.org**.

Medical Care Management Corporation

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 State. MCMC provides external reviews to patients, providers, health plans and employers nationwide and has reviewed numerous cases in all areas of medicine. MCMC strives to provide high quality independent reviews in a timely manner. MCMC has a comprehensive network of clinical peer reviewers, including physicians who are board certified specialists, many of whom practice in the nation's leading medical centers. You may visit MCMC's web site at **www.mcmcllc.com**.

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