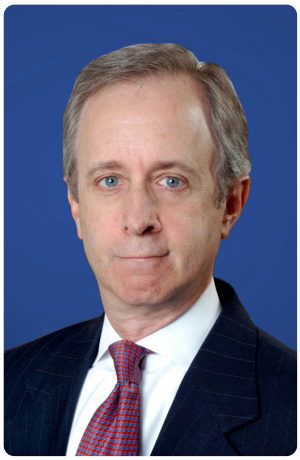
Medical Society of the State of NY – Appealing Healthcare Claim Denials: Know Your Rights

FEATURED ATTORNEY



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As we monitor the healthcare legal landscape each year, a number of new or amended laws in New York greatly impact our clients and their practices. As healthcare providers, few laws are more significant to you and your medical practice than those that ensure you are appropriately reimbursed for the care you provide. The New York State Legislature has expanded your previously existing right to an external appeal of claim denials. This right significantly impacts your ability to obtain an independent, external review of utilization in cases of denials for services that you provided which, in your medical judgment, were necessary to properly care for your patients – those who trust you with their health. Providers may now request external appeals on their own behalf for both concurrent and retrospective adverse determinations. However, this process triggers additional considerations that you, the provider, must carefully weigh and that your patients must understand. We'll begin with an overview of the claim denial appeals process in New York.

Reviews and Denials by Health Plans

Health plans are permitted to (and often do) deny payment for services, procedures, and treatments that they consider medically unnecessary, experimental, investigational, a clinical trial, a rare disease treatment, or, in some cases, out-of-network. The notice of denial must be in writing, sent within the time frame established by New York State law, and include the following: 1.) The specific reason(s) for denial with the medical explanation, if any; 2.) A statement that the clinical review criteria (medical standards) the plan used to make its decision are available to the member upon request; 3.) Instructions on how to file an internal appeal with the plan and what information the plan needs for the appeal; and; 4.) Notice of the right to an external appeal with an independent third party.

Health plans are required to make a determination and notify a provider or consumer of the denial of a claim within a specified period of time after receiving all “necessary information” for that claim. This “necessary information” encompasses all clinical or other information relating to an individual’s treatment required by the health plan in order to help make its determination about whether the care provided was necessary and appropriate. Additional information may be requested by the health plan if deemed necessary. The receipt of all necessary information triggers the beginning of relevant time restrictions which depend on the types of review.

There are three types of review which may result in an Initial Adverse Determination (“IAD”), or claim denial: concurrent review, pre-authorization review, and retrospective review.

Concurrent review arises where there has been a request for an extension or continuation of care that is ongoing. It also applies where there is a request for additional services for a patient undergoing a course of continued treatment. In these situations, health plans are required to notify providers or consumers within one business day of receipt of all necessary information, and this must be done via telephone and letter to the provider or consumer.

Preauthorization review occurs prior to the provision of services. Necessary information, once submitted, is reviewed and coverage for the service is either approved or denied. The health plan must communicate the denial within three business days after receipt of all necessary information.

Retrospective review arises when the health plan decides that treatment that has already been provided was not medically necessary or is not covered (e.g., experimental). Retrospective adverse determinations do not apply to pre-authorization determinations or initial determinations involving either continued or extended health care services, or additional services for a patient undergoing a course of continued treatment. A determination must be made within thirty days of receipt of all necessary information.

The Health Plan Denied Payment: Now What?

For situations where a health plan issued an IAD without consulting the treating doctor who recommended the service under review (or his documentation), a process exists for providers to request reconsideration. The reconsideration is performed by the same individual at the health plan that issued the initial IAD. Please note that except in cases of retrospective reviews, such reconsideration shall occur within one business day of receipt of the request.

An IAD by a health plan may be appealed. There are generally two types of internal appeals available with the health plan – standard appeals and expedited appeals. Any decision where the health plan has determined that care was not medically necessary may be appealed through a standard appeal. When a standard appeal is used, the plan must issue a decision within 60 days of the receipt of all necessary information. This decision must be communicated to the provider or consumer within two business days of the decision. Expedited Appeals occur where the plan’s initial denial of care involved a continuation or extension of healthcare services, or where the healthcare provider believed that an immediate appeal was warranted. In these cases, a decision by the health plan must be reached within two business days of receipt of all necessary information.

It is extremely important to keep track of these time frames, as non-timely determinations by the health plan will lead to an automatic reversal of the initial adverse determination and the claim must be paid; in other words, if the health plan fails to meet the required time frame, you (and your patients) prevail and no

external appeal is necessary.

The Final Adverse Determination and External Appeal

A Final Adverse Determination (“FAD”) is an ultimate upholding of the IAD. When FADs are issued, the right to an external appeal is triggered. Some health plans may offer the option of a second internal appeal, but this does not preclude the provider or consumer from filing an external appeal. The external appeal and second internal appeal may be filed simultaneously, but regardless, the external appeal must be filed with the State within 45 days of the plan’s final adverse determination or the health plan’s letter waiving the internal appeal process. If this timeframe is not met, providers and consumers will forfeit the right to the external appeal.

As mentioned previously, if a health plan denies an initial appeal, a provider or consumer may file both a secondary internal appeal to the health plan, if available, and an external appeal with the Insurance Department, in order to ensure that the 45 day time frame does not expire. Individuals bringing external appeals can assist in the appeals process by making sure that all necessary attestations by the physician, including the relevant and necessary peer-reviewed literature, are provided.

In an external appeal, independent external review agents appointed by the New York State Department of Insurance review eligible appeals. External appeals are only available following a Final Adverse Determination. These agents are certified by the New York State Insurance Department and the New York State Health Department, and they utilize medical experts in their reviews. The number of experts that review the appeal varies based upon whether the review is of a medical necessity claim (one reviewer) or whether the care provided was experimental, investigational, a clinical trial denials or a rare disease denial (three reviewers, up to three for out-of-network reviews). Reviewers are health care professionals in the same or similar specialty, and they decide whether to overturn, uphold, or uphold in part the denials of health plans.

Decisions by the independent external review agents will be made in 3 days for expedited appeals or 30 days for standard appeals. It is important to note that the external appeal agent’s decision is final, and it is binding on the patient and the patient’s health plan. If a provider is due payment from a health plan based on an external appeal, the payment must be made within 45 days of the date the plan was notified. If payments are not made within that timeframe, the provider is entitled to interest payments. Note that providers may not pursue reimbursement from the patient if a denial is upheld (however, it is permitted to look to collect a copayment, coinsurance, or deductible owed).

Generally, legal action may not be taken against a health plan after an external appeal decision. However, New York courts do seem to suggest that there may be a small window of opportunity for consumers who have had their adverse decisions upheld. In a 2003 court case, the insured brought an administrative proceeding against the Superintendent of Insurance based on an external appeals agent’s decision upholding a health plan’s denial of coverage for medical treatment. The New York State Supreme Court wrote that external appeal agents function in an administrative capacity on behalf of the State, and that these types of administrative proceedings were thus the proper vehicle for reviewing an external agent’s determination to uphold the health plan’s denial of coverage.

Additionally, the New York State Supreme Court wrote in another case that the external appeal of an insurer’s determination was not a binding arbitration to which the parties agreed in the insurance contract.

In that case, the court found that although the determination of an external appeal agent was binding on the plan and the insured, the law also provided that the external appeal agent's determination was admissible in any court proceeding. The court's opinion provides grounds upon which a provider could argue that an adverse external appeal decision may be reviewed in the courts.

Paying for the External Appeal

With the expansion of the right for providers to bring an external appeal, there was recognition by the Legislature that the obligation to pay for the external appeal must be imposed even-handedly to ensure appropriate utilization of the system. The payment obligation can fall on the carrier, the provider, or both. This variable is a significant factor to consider in determining if an external appeal should be undertaken.

Based on the depth of review, fees for an external appeal can range from hundreds to even thousands of dollars. Under the Insurance Law and Public Health Law, prior to January 1, 2010, payment for the external appeal was solely the responsibility of the health plan. Now, if a provider requests an external appeal for concurrent adverse determinations and the denial is upheld in whole, responsibility for payment for the external appeal falls upon the provider. If the denial is upheld only in part, the cost is evenly split between the provider and the healthcare plan. If the provider prevails in total, payment for an external appeal is the responsibility of the health plan. For retrospective adverse determinations, the health plan will pay the cost of the external appeal. In these cases, health plans may charge providers a small fee, but this fee will be returned to the provider if the external appeal leads to an overturning of the health plan's denial in whole or in part.

Conclusion

The external appeal is a powerful tool in the provider's arsenal for recouping payments and overturning denials when carriers make arbitrary and capricious decisions to deny healthcare services or payment. However, it is imperative that providers and consumers keep close track of the important time frames and necessary components of the appeal in order to maximize their opportunity for success. Being aware of both the procedures and options available will assist you in navigating through the appeals process available to you in New York.

If you have any questions about the external appeal process in New York, please contact our attorneys in the Managed Care Division. We can be contacted at Abrams Fensterman, LLP in our Brooklyn office at (718) 215-5300.