

LEGAL

NEW PATIENT PROTECTIONS IN NEW YORK STATE: EXTERNAL APPEALS OF DENIALS OF COVERAGE

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Most insurance and HMO policies exclude coverage for health care services which are not "medically necessary" and for experimental or investigational treatments. Under current law, HMOs and insurers are required to have internal procedures for patients to appeal coverage determinations concerning medical necessity. When a plan denies coverage for a particular health care service, the patient often has no alternative but to turn to the courts for redress. The litigation alternative is costly and uncertain for both patient and health plan.

In response to this situation, the New York State Legislature recently passed a bill which would allow patients to obtain an external review of adverse determinations by their health plan concerning medical necessity or the coverage of certain experimental or investigational treatments. The bill prohibits insurers and HMOs from excluding coverage of health care services on the basis that the services are not medically necessary or are experimental or investigational if the coverage has been recommended by an external appeal agent.

Under the bill, enrollees may request an external appeal when coverage of a health care service is denied on the grounds that the service is not medically necessary. Enrollees also may request an external appeal when coverage is denied on the basis that the service is experimental or investigational. In the latter situation, the enrollee's attending physician must certify that the enrollee has

a life-threatening or disabling condition or disease (a) for which standard health services have been ineffective or (b) for which there does not exist a more beneficial standard procedure covered by the health plan or (c) for which there exists a clinical trial. In addition, the enrollee's physician must have recommended a procedure that is likely to be more



beneficial than any standard procedure covered by the plan, which recommendation must be supported by medical and scientific evidence, or must have recommended a clinical trial for which the enrollee is eligible.

Generally, an external appeal must be initiated within 45 days following an enrollee's receipt of a final determination that the

plan has denied coverage. An external appeal may be requested by the enrollee or, in connection with a retrospective denial of coverage, by the enrollee's health care provider. The external appeal agent who will consider the appeal will be randomly assigned. A decision must be rendered by the agent no more than 30 days later. The decision period is reduced to three days if the enrollee's attending physician states that a delay providing the service would threaten the health of the enrollee.

The cost of an external appeal is paid by the health plan. The plan may charge the enrollee a fee of up to \$50 per appeal. However, the fee is refunded if the external appeal agent overturns the plan's denial of coverage. External appeal agents will be subject to stringent qualification and conflict of interest standards and must be certified by the Commissioner of Health and the Superintendent of Insurance.

Importantly, the bill imposes uniform standards on the review of coverage determinations. Such standards will help assure that there will be consistency among plans concerning determinations regarding medical necessity and the coverage of experimental and investigational treatments.

The bill, which will become effective on July 1, 1999, was delivered on July 24, 1998 to Governor Pataki for signature.

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