News from the Managed Care Battlefield: Out-of-Network Denials and the New York State External Appeal Law

By Kathleen Duffett, R.N., J.D.

I. In the Beginning . . .

In the beginning, providers took care of patients first and talked to the health insurance companies about payment later. But, as Billy Joel sings, "They started to fight when the money got tight and they just didn't count on the tears."

In the 1990s, managed care in New York State started to take off, forever altering the provider/patient/insurer relationship. Generally speaking, a patient with managed care coverage could no longer go to whichever doctor or hospital he or she wanted to or self-refer to a specialist. Providers who wanted to get paid from managed care organizations (MCOs) for performing surgeries, providing specialty consults, etc., now needed to make sure that the MCO authorized this care. And so the fight was on—patients and their providers versus managed care.

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The mediator of this fight was none other than the State of New York. In 1996, New York State enacted the Managed Care Reform Act (the "Act"),[1] more commonly known as the Managed Care Consumer Bill of Rights.[2] Among other things, the Act established the right of managed care members to contest certain health plan decisions through mandatory grievance and utilization review[3] appeal processes and to obtain emergency care without prior authorization.

But the battle raged on. The state's next attempt at reconstructing the managed care playing field focused on creating an external appeal process, which would allow managed care members to appeal medical necessity denials to an independent third party. The External Appeal Law,[4] which took effect in July 1999, granted managed care members this right. However, the right of a health care provider to initiate an external appeal on the provider's own behalf was limited to those situations where the health plan had issued a retrospective denial.[5]

For members, the new External Appeal Law was a welcome change to the existing landscape. However, health care providers took issue with their limited right to independently initiate an external appeal only when the denial had been issued retrospectively. This issue persists to the present day.[6]

Another persistent issue has been the right of members to access the external appeal process when a request for service is denied because the provider is out-of-network (i.e., not part of the member's health plan network, also referred to as a non-participating provider). This article explores the application of a member's out-of-network appeal rights as of 4/1/08, the effective date of such new rights.

II. Out-of-Network Denials and the New York State External Appeal Process

Chapter 451 of the Laws of 2007 amended Article 49 of the Public Health Law[7] to address out-of-network denials. Effective 4/1/08, a member has the right to pursue an external appeal whenever a health plan denies the out-of-network service that the member has requested but recommends (i.e., approves) an alternate in-network service that the health plan believes is not "materially different" from the requested out-of-network service.[8]

Of note, the right to pursue an out-of-network appeal applies only when the health plan denies a pre-authorization request[9] for such services.

III. Application of Article 49 to Out-of-Network Denials as of April 2008

A. Definition of Out-Of-Network Denial

New subsection PHL 4900(7-f) defines the term out-of-network denial. In part, it reads:

> "Out-of-network denial" means a denial of a request for pre-authorization to receive a particular health service from an out-of-network provider on the basis that such out-of-network health service is NOT MATERIALLY DIFFERENT (emphasis added) than the health service available in-network. The notice of an out-of-network denial provided to an enrollee shall include information explaining what information the enrollee must submit in order to appeal the out-of-network denial pursuant to [PHL § 4904(1-a)]. An out-of-network denial under [PHL § 4900(7-f)]

> does not constitute an adverse determination as defined in [PHL § 4900(1)]. . . .

The last sentence attempts to make clear that out-of-network denials are *not* medical necessity determinations. However, somewhat confusingly, the appeal process for out-of-network denials now includes the right to external appeal, a process that historically has been limited to medical necessity issues.

Interestingly, the last sentence of the definition reads:

> Notwithstanding any other provision of this subdivision, an out-of-network denial shall not be construed to include a denial for a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by the enrollee.

"Referral" is not defined in Article 49. However, it is defined in the New York State Department of Health (DOH) managed care regulations as "the internal mechanism utilized by the MCO to allow members to access needed services."[10] Typically, this means the process by which the member's provider submits the request for service (whether by phone, facsimile, mail or electronic means) to the member's health plan for utilization review.

The definition of out-of-network denial makes clear that a member does *not* have the right to external appeal if the health plan (or health plan's participating provider) refuses to generate a referral to an out-of-network provider when the basis for the refusal is the availability of an in-network provider. In this case, the member would have grievance rights,[11] which do not result in access to the External Appeal Program.

B. Internal Appeal of Out-of-Network Denials

New subsection PHL 4904(1-a) explains a member's internal appeal rights (i.e., the right to appeal to the health plan) in the event of an out-of-network denial.

> An enrollee or the enrollee's designee may appeal an out-of-network denial by a health care plan by submitting:
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> (a) a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, that the requested out-of-network health service is MATERIALLY DIFFERENT (emphasis added) from the health service the health care plan approved to treat the insured's health care needs; and
>
> (b) two documents from the available medical and scientific evidence that the out-of-network health service is likely to be MORE CLINICALLY BENEFICIAL (emphasis added) to the enrollee 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 (emphasis added).

The terms "materially different" and "clinically beneficial" in this subsection are not defined in the statute. And the standard "for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service" almost defies parsing. However, "medical and scientific evidence" is defined (at length) in PHL 4900(7-e).

The procedural requirements[12] for internal appeals of ordinary medical necessity denials are not nearly as proscriptive as the out-of-network internal appeal process described above. Also, meeting the out-of-network internal appeal procedural requirements is the responsibility of the member and the member's attending physician. Arguably, this can be a daunting prospect for the average member (i.e., a layperson), even with the assistance of his or her attending physician.

C. External Appeal of Out-of-Network Denials

1. Right to External Appeal of Out-of-Network Denial

New subsection PHL 4910(2)(c) speaks to a member's right to an external appeal of an out-of-network denial.

> An enrollee [and] the enrollee's designee . . . shall have the right to request an external appeal when:
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> . . . the enrollee has had coverage of the health service (other than a clinical trial to which paragraph (b) of this subdivision shall apply), which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health service is out-of-network and AN ALTER-

> NATE RECOMMENDED HEALTH SERVICE IS AVAILABLE IN-NETWORK (emphasis added), and the health plan has rendered a final adverse determination with respect to an out-of-network denial or both the health plan and the enrollee have jointly agreed to waive any internal appeal; and
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> (ii) the enrollee's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, certifies that the out-of-network health service is MATERIALLY DIFFERENT (emphasis added) than the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more CLINICALLY BENEFICIAL (emphasis added), than the alternate recommended in-network treatment and THE ADVERSE RISK OF THE REQUESTED HEALTH SERVICE WOULD LIKELY NOT BE SUBSTANTIALLY INCREASED OVER THE ALTERNATE RECOMMENDED IN-NETWORK HEALTH SERVICE (emphasis added).

Again, the procedural requirements that a member and the member's attending must meet when pursuing an external appeal of an out-of-network denial are much more detailed than the procedural requirements for an external appeal involving an ordinary medical necessity denial.[13]

2. External Review of Out-of-Network Denials: Procedural Requirements

New subsection 4914(2)(d)(C) lays out the procedure the external appeal agent must follow when reviewing an external appeal of an out-of-network denial.

> For external appeals requested pursuant to [PHL § 4910(2)(c)] relating to an out-of-network denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network health service shall be covered by the health plan.
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> (i) The external appeal agent shall assign one clinical peer reviewer to make a determination as to whether the out-of-network health service is materially different from the health service available in-network.
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> (ii) If a determination is made [BY THE ONE CLINICAL PEER REVIEWER] that the out-of-network health service IS NOT (emphasis added) materially different from the health service available in-network, the out-of-network health service SHALL NOT (emphasis added) be covered by the health plan.
>
> (iii) If a determination is made [BY THE ONE CLINICAL PEER REVIEWER] that the out-of-network health service IS (emphasis added) materially different from the health service available in-network, the external appeal agent shall assign a panel with an additional two or a greater odd number of clinical peer reviewers which shall make a determination as to whether the out-of-network health service shall be covered by the health plan; provided that such determination shall:
>
> (1) be accompanied by a written statement that:
>
> (I) the out-of-network health service shall be covered by the healthcare plan either: when a majority of the panel of reviewers determines, upon review of the health service requested by the enrollee, the alternate recommended health service proposed by the plan, the clinical standards of the plan, the information provided concerning the enrollee, the attending physician's recommendation, the applicable medical and scientific evidence, the enrollee's medical record, and any other pertinent information that the out-of-network health service is likely to be more clinically beneficial than the proposed in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the in-network health service; or
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> (II) uphold the health plan's denial of coverage.

(2) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

(3) be binding on the plan and the enrollee; and

(4) be admissible in any court proceeding.

Once again, when compared with the procedural requirements that the external appeal agent must follow when reviewing ordinary medical necessity determinations,[14] the out-of-network requirements are considerably more proscriptive.

IV. Application of Out-of-Network Requirements to the Pre-authorization Process

The new requirements affect the handling of pre-authorization requests for out-of-network services as follows.

SITUATION: A member's provider submits a pre-authorization request for an out-of-network service to the member's health plan for utilization review.

Under Article 49's requirements as of 4/1/08, there are four possible outcomes.

1. **Approve the request because the service is medically necessary and is not available in-network.**

   Explanation: Under existing law, if there is a request for an out-of-network service and there is no available in-network service, the health plan *must* make a referral to an appropriate out-of-network provider at no cost to the member other than what the member would have paid in-network.[15]

   As a related matter, the New York State DOH managed care regulations require that managed care organizations "establish a process for the resolution of requests for medically necessary services to be provided by [out-of-network] providers when such services are not available in-network. Such process shall require the approval of the commissioner prior to implementation and shall thereupon be included in the member handbook."[16]

2. **Deny the request because the service is out-of-network and the service is readily available in-network.**

   Explanation: The New York State Insurance Department (SID), which is responsible for the administration of the External Appeal Program, has clarified that denial of a request for out-of-network services when the out-of-network services are readily available in-network is a benefit denial, not a medical necessity denial.[17] In other words, if the requested out-of-network service is available in-network essentially "as is," then the member's right to contest this determination is limited to a grievance.[18] As noted earlier, the grievance process does not provide the member with access to the External Appeal Program in the event the health plan upholds the denial.

3. **Deny the request because the service is out-of-network but approve an alternate health service that is available in-network and is not materially different from the out-of-network service that the member is requesting.**

   Explanation: This is the real change that Chapter 451 of the Laws of 2007 makes to the External Appeal Program. In this circumstance, as of 4/1/08, the member is entitled to internal and external appeal rights that are consistent with new out-of-network appeal requirements described earlier in this article. If the member ultimately decides to pursue an external appeal, the external review agent must review the appeal consistent with the requirements of new PHL § 4914(2)(d)(C) (see Section III(C)(2), above).

4. **Deny the request because the service is not medically necessary regardless of whether the service is provided in-network or out-of-network.**

   Explanation: This is the standard denial for lack of medical necessity that has existed since the inception of the Managed Care Reform Act of 1996. The member has the same internal and external appeal rights that have existed under Article 49 since April 1997 and July 1999, respectively.

V. General Impressions

There was little fanfare involved with publicizing the new out-of-network appeal rights when they took effect on 4/1/08. However, on this date, the SID did post out-of-network appeal information to the "Latest Updates" section of its External Appeal Information home page.

Although members now have an express right to internal and external review of out-of-network denials, the procedural requirements of the out-of-network appeal process are fairly daunting. Also, two of the crucial terms, namely, "materially different" and "clinically beneficial," are not defined in the statute or in the existing external appeal regulations.[19] Likewise, the "for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service" standard is not a model of clarity, leaving it ripe for challenge.

Out-of-network appeal rights are relatively recent. It will be interesting to see if, over time, members exercise their appeal rights in the event of an out-of-network denial. Also of interest is whether any consumer rights attorneys will file lawsuits challenging the terms "materially different" and "clinically beneficial," or challenge the adverse risk standard, particularly as these terms and standards are applied by the external appeal agents.

Endnotes

1. Chapter 705 of the Laws of 1996.
2. Generally speaking, these rights apply to managed care members who receive their health insurance coverage from an HMO with a certificate of authority under Article 44 of the Public Health Law (PHL), a for-profit insurer licensed under Article 42 of the Insurance Law or a not-for-profit insurer licensed under Article 43 of the Insurance Law. Of note, members of Medicare managed care plans or self-insured plans are not covered by the New York State Managed Care Consumer Bill of Rights.
3. Utilization review means the process for determining whether a service is medically necessary. The definition of medical necessity is typically included in the subscriber contract.
4. Chapter 586 of the Laws of 1998. The New York State Insurance Department (SID) administers the External Appeal Program.
5. A retrospective denial (a.k.a. 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 an initial determination involving continued or extended health care services, or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider. . . ." (*see* 11 N.Y.C.R.R. 410.2(i)).
6. The seminal case on this issue is *HANew York State v. Serio* (Decision and Order Index No. 3133-01) (Supreme Court, Albany County, February 2002). Bills that were introduced in the 2007–2008 legislative session attempting to expand a health care provider's right to independently initiate an external appeal for denials other than retrospective ones included A.8321 (Gottfried) and S.4481-A (Seward)/A.11737 (Morelle). None of these bills became law. In January 2009, Assemblyman Gottfried introduced A.792 to address this and other review issues.
7. Chapter 451 made corresponding changes to Article 49 of the Insurance Law, even though the references in this article are to Article 49 of the Public Health Law.
8. PHL § 4910(2)(c)(i).
9. A pre-authorization request is a request for utilization review of a service prior to the service being provided (*see* PHL § 4900(8); *see also* PHL § 4903(2)).
10. 10 N.Y.C.R.R. 98-1.2(ii).
11. A grievance is essentially an appeal by a member in response to a health plan's denial of coverage for a reason other than medical necessity (*see generally* PHL § 4408-a and Insurance Law § 4802).
12. See PHL § 4904(2) for the procedural requirements for expedited appeals and PHL § 4904(3) for the procedural requirements for standard appeals.
13. See PHL § 4910(2)(a) for the procedural requirements for external appeals involving medical necessity determinations.
14. *See* PHL § 4914(2)(d)(A).
15. PHL § 4403(6)(a).
16. 10 N.Y.C.R.R. 98-1.13(a).
17. See Question 7 of the "More Frequently Asked Questions" section of the New York State Insurance Department's External Appeal home page, http://www.ins.state.ny.us/extapp/extappqa.htm (accessed July 17, 2008).
18. Section 4408-a of the PHL and Section 4802 of the Insurance Law state the required elements that a health plan must incorporate into its internal grievance process.
19. See the DOH external appeal regulations at 10 N.Y.C.R.R. Part 98-2 and the SID external appeal regulations 11 N.Y.C.R.R. Part 410.

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