Wouldn't It Be Nice—Utilization Review Determinations, External Appeals and the Benefits of Being a Provider Covered by the NYS Access to End of Life Care Law

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

"Wouldn't it be nice if we could get paid
After all the work we've done was through?
And wouldn't it be nice not to have to argue
With the plan about the good care we provided to you?

I know this law will make it so much better—
For us to say "You're admitted!" and can stay—forever(?)
Oh wouldn't it be nice?"

(Sung to the tune of the Beach Boys "Wouldn't It Be Nice")

Payment for services—whether prompt or otherwise—has been and remains a major issue for health care providers, both individual and institutional. This is especially so when the payor is a managed care plan. Over the past several years, New York State has taken a number of different measures, both direct and indirect, to ensure that providers get paid for the services they provide to members of managed care organizations ("MCOs"). This article will give a history of managed care regulation in NYS related to utilization review and will discuss in detail New York State's Access to End of Life Care Law, a unique piece of health care legislation.

First Step: The 1996 Managed Care Reform Act

In 1996, New York State passed the Managed Care Reform Act,[1] which created a statutory framework for utilization review ("UR") decision making. UR decision making involves approving or denying a request for a treatment or health care service based on a determination of the medical necessity of that treatment or service.[2] UR decisions were characterized under the Act as prospective (a.k.a., preauthorized), concurrent or retrospective. Under the Act, health plans[3] that performed UR were required to make their determination within a specific time frame.[4] If the health plan denied the request, an adverse determination letter had to be provided, which had to include the specific clinical reason for the denial, the availability of the clinical review criteria relied upon to make the determination and the member's (and, in retrospective review cases, the provider's) appeal rights within the health plan.[5] Failure to make the determination within the required time frame was deemed a denial under the law, which could be appealed to the health plan. Like denials, appeals had to be carried out within a specific time frame.[6] If the health plan denied the appeal, another adverse determination letter had to be provided.

The Act benefited providers in that it compelled HMOs and other insurers to make UR decisions in a timely manner which , as a practical matter, gave providers a more concrete framework for initiating UR requests and tracking UR decisions. It also gave all providers (i.e., participating and non-participating providers) a statutory right to appeal retrospective review denials. However, it was lacking in certain significant respects, which led to its amendment in 1998.

When at First You Don't Succeed: The 1998 NYS External Appeal Law

The 1996 Managed Care Act did not remedy all the perceived problems with HMOs and other insurers conducting UR. Providers and members continued to complain that their appeal rights were essentially illusory as the appeal was heard by the same organization that issued the denial, namely, the member's health plan. Consequently, the 1998 NYS External Appeal Law was enacted.[7] Effective as of July 1, 1999, the External Appeal Law provided members and, in some cases, providers, with the right to appeal a denial by a health plan to an independent third party after the member or provider completed at least one level of internal appeal through the member's health plan. The Department of Insurance was charged with the responsibility for managing the External Appeal Program and for contracting with external agents to perform the medical necessity reviews.[8]

Although quite beneficial to consumers, the External Appeal Law resulted in a limited benefit for most providers. This was so because the External Appeal Law limited a provider's independent right to external appeal to decisions involving retrospective review, i.e., cases in which the health plan initiated UR after the services had been rendered in their entirety.[9] As a practical matter for acute care inpatient facilities, most health plans initiated UR some time *during* the patient's inpatient stay, thus making such reviews concurrent. Under the statute, providers did not have an express, independent right to initiate an external appeal for concurrent review denials. However, members or their designees had the right to appeal a denial regardless of the type of review on which it was based. Consequently, if a member appointed an acute care facility as the member's designee, then the facility would stand in the shoes of the member and could initiate an external appeal of a concurrent review denial on the member's behalf, right? Not exactly.

In the regulations implementing the 1998 External Appeal Law, the Departments of Health and Insurance

defined "designee" as "for the purpose of requesting an external appeal, [a designee is] a person authorized in writing by an insured to assist such insured in obtaining access to health care services. If the insured has already received health care services, a designee shall not be authorized for the purpose of requesting an external appeal."[10] Since most acute care facilities were not notified of the concurrent review denial until after the patient had received the services, the regulatory definition precluded the member from appointing the facility as the member's designee. As evidenced in their first annual report regarding the External Appeal Program, the Departments of Health and Insurance made quite clear their position on this, stating, "[The External Appeal Program] was not intended to permit disputes between providers and health plans that were not based upon a retrospective adverse determination to be subject to the external appeal process. A definition of designee was added to the regulations to ensure that a designee would have to act on behalf of a patient and could not use the external appeal process as a mechanism to arbitrate payment disputes that would not otherwise be eligible for external appeal."[11] This did not sit well with the provider community, which decided to take action.

When You Just Can't Take No for an Answer: *HANYS v. Serio*

In November 2001, the Healthcare Association of New York State ("HANYS") and other interested parties sued the state Departments of Health and Insurance, objecting to their restrictive interpretation and implementation of Article 49 of the Insurance and Public Health Laws. Specifically, the lawsuit challenged the Departments' authority to promulgate the following definitions of "designee" and "retrospective adverse determination":

> **Designee**—means, for the purpose of requesting an external appeal, a person authorized in writing by an insured to assist such insured in obtaining access to health care services. If the insured has already received health care services, a designee shall not be authorized for the purpose of requesting an external appeal.[12]
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> **Retrospective adverse determination**—means 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 healthcare services, or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider pursuant to Section 4903(c) of the Insurance Law.[13]

The Supreme Court, Albany County, decided the case in February 2002. The court upheld the Departments' authority to promulgate the definition of retrospective adverse determination but it struck down the Departments' definition of designee. In doing so, the court stated, "the Court cannot state a rational basis exists for the [Departments'] definition of "designee" . . . This definition appears to be drafted solely to restrict the right of an enrollee to appoint a designee . . . The Court finds this restriction to both materially change and in direct contradiction of the law as written and must be invalidated."[14]

By striking down the definition of designee, the court effectively allowed a patient to designate a hospital as his or her representative to appeal inpatient services denied by a health plan as a result of concurrent utilization review. Thus, if a hospital obtained an appointment as a designee, the hospital would have access to the External Appeal Program in the event the health plan denied the first level appeal. This would be so because the statute authorizes enrollees or their authorized representatives to appeal all final adverse determinations, regardless of whether the underlying review was concurrent or retrospective.

Although viewed as a victory for providers when it was issued, the tangible benefits of the *HANYS v. Serio* decision remain to be seen. For the past two years, HANYS has worked with outside counsel to develop forms and other materials to facilitate the appointment of hospitals as designees. Anecdotally, it appears that most facilities have not attempted to utilize the *HANYS v. Serio* decision to pursue appeals of medical necessity denials.

Some Guys Have All the Luck: The Benefits of Being a Provider Covered by the NYS Access to End of Life Care Law

As discussed above, New York State law provides a framework for turnaround times regarding UR decisions. This helps members and providers in that it establishes bright-line rules for the timely processing of UR requests. However, a provider's right to effectively and efficiently appeal denials of UR decisions, particularly concurrent review denials, is hamstrung by regulatory issues (such as the definition of retrospective adverse determination) and operational issues (such as how and when to ask a patient to appoint a facility as his or her designee for the purpose of pursuing appeals). But not all providers suffer from this burden. In fact, there is one class of provider that receives special treatment under New York State law: acute care facilities licensed pursuant to Article 28 of the Public Health Law specializing in the treatment of terminally ill patients. Calvary Hospital in the Bronx, New York, appears to be the primary (if not the only) beneficiary of the Access to End of Life Care Law.[15]

Sponsored by Senator Hannon and enacted into law in 1999,[16] the Access to End of Life Care Law[17] essentially guarantees admission to a facility such as Calvary if the patient's medical condition meets certain requirements. As a result of its amendment in 2000,[18] the statute also dictates how much such a facility will be paid for the admission. Perhaps most interestingly, the Access to End of Life Care Law controverts the usual practice under the External Appeal Law in that it requires the health plan, not the member, to initiate an expedited external appeal if the health plan disagrees with the decision to admit (or to continue services).

Specifically, the Access to End of Life Care Law requires that health plans "shall provide an enrollee diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the patient's attending health care practitioner) with coverage for acute care services at an acute care facility licensed pursuant to article twenty-eight of this chapter specializing in the treatment of terminally ill patients, if the patient's attending health care practitioner, in consultation with the medical director of the facility, determines that the enrollee's care would appropriately be provided by the facility."[19] If the health plan disagrees with this determination, it cannot deny the admission. Rather, it must initiate an expedited external appeal with the Department of Insurance.[20] If the health plan does not initiate an expedited external appeal, it is required to reimburse Calvary for services provided subject to the reimbursement requirements of the statute and other limitations otherwise applicable under the enrollee's contract.[21] Significantly, the statute mandates with specificity how Calvary should be reimbursed if it is not a participating provider in the member's health plan network.[22]

Conclusion

Payment for services rendered remains an ongoing struggle for health care providers, particularly acute care facilities. Although the law provides some rights with regard to UR turnaround times and external appeal rights, most providers feel that these rights are weak at best. Some providers, such as Calvary Hospital, have been fortunate enough to convince the New York State legislature to pass a law that basically guarantees admissions and payment (subject to certain conditions). Hope for other providers may come in the form of Assembly Bill A.6844-A and Senate Bill S.5744-A, which, among other things, redefine the definition of "retrospective adverse determination" in a way that is much more favorable to inpatient facilities and strengthen a provider's right to receive payment for services that were preauthorized.[23] Lest providers become too hopeful, it should be noted that these bills have been making the rounds since 1999 and have yet to be made into law. Could it be possible that Nietzche was thinking of health care providers when he said, "That which does not kill us makes us stronger"?

Endnotes

1. Chapter 705 of the Laws of 1996.
2. *See, e.g.*, N.Y.S. Public Health Law § 4900(8) ("PHL").
3. "Health plans" as used in this article includes HMOs and any other health insurers that conduct utilization review.
4. PHL § 4903(2-4).
5. PHL § 4903(5).
6. PHL § 4904(2-3).
7. Chapter 586 of the Laws of 1998.
8. *See generally* N.Y. Comp. Codes R. & Regs. tit. 11, §§ 410 *et seq.* ("N.Y.C.R.R.").
9. See definition of "retrospective adverse determination" at 10 N.Y.C.R.R. § 98-2.2(h) and 11 N.Y.C.R.R. § 410.2(i).
10. *See* 11 N.Y.C.R.R. § 410.2(d). The N.Y.S. DOH implementing regulations define designee the same way. *See* 10 N.Y.C.R.R. § 98-2.2(c).
11. *See* N.Y.S. DOI and DOH External Appeal Program Annual Report, July 1, 1999-June 30, 2000, *available at* http://www.ins.state.ny.us/acrobat/extapp.pdf.
12. See the Department of Insurance regulations at 11 N.Y.C.R.R. § 410.2(d). The Department of Health's regulation reads the same except that it substitutes "enrollee" for "insured" (*see* 10 N.Y.C.R.R. § 98-2.2(c)).
13. See the Department of Insurance regulations at 11 N.Y.C.R.R. § 410.2(i). The Department of Health's regulation reads the same except that it substitutes "enrollee" for "insured" and makes reference to the Public Health Law rather than the Insurance Law (*see* 10 N.Y.C.R.R. § 98-2.2(h)).
14. *Healthcare Association of New York State v. Gregory V. Serio*, Decision and Order, Index No. 3133-01, RJI No. 0101ST857 (Sup. Ct., Albany Co., Feb. 8, 2002).
15. PHL § 4406-e (McKinney's 2002); NYS Insurance Law § 4805 McKinney's 2000, Supp. 2004).
16. Chapter 559 of the Laws of 1999.
17. PHL 4406-e applies only to members of HMOs that are certified under Article 44 of the Public Health Law or are licensed under Article 43 of the Insurance Law. Access to end-of-life care obligations for all other types of health insurers are governed by section 4805 of the Insurance Law. It should be noted that neither law applies to Medicare members as federal preemption precludes such application.
18. Chapter 572 of the Laws of 2000.
19. PHL § 4406-e(2); N.Y.S. Insurance Law § 4805(a).
20. PHL § 4406-e(3); N.Y.S. Insurance Law § 4805(b).
21. PHL § 4406-e(4); N.Y.S. Insurance Law § 4805(c).
22. *Id.*
23. The full text of both bills is available through http://public.leginfo.state.ny.us/menugetf.cgi.

Kathleen Duffett, R.N., J.D., Attorney at Law, provides high-quality and cost-effective legal and consulting services for health care organizations and providers. Her professional strength is being able to make complex health care regulations understandable to the individuals who have to implement them. Her practice areas include fraud and abuse, HIPAA, managed care and patient care issues. Ms. Duffett can be contacted at (845) 265-3965 or at kduffett@optonline.net.