

New York State Insurance Department and
New York State Department of Health

NEW YORK STATE
External
Appeal
Program

ANNUAL REPORT

January 1, 2005 – December 31, 2005



Eliot Spitzer
Governor

A REPORT ON EXTERNAL APPEALS IN NEW YORK

January 1, 2005 through December 31, 2005

New York State
Department of Insurance
Health Bureau
One Commerce Plaza
Albany, New York 12257

Report Preparation:

Lisette Johnson: (518) 474-4098, ljohnson@ins.state.ny.us
Colleen Rumsey: (518) 486-7815, crumsey@ins.state.ny.us

External appeal information is also available on the Insurance Department's Web site at www.ins.state.ny.us or by calling 1-800-400-8882.

* With thanks and appreciation to Shannon Tahoe and Amy Caudill for their contributions.

Table Of Contents

Introduction	3
Appealing Denials With Health Plans Utilization Review Requirements and Agents that Contract with Health Plans	4 - 9
The New York External Appeal Program	
Volume of External Appeal Requests Received by the Insurance Department ...	10 - 11
Volume of External Appeal Hotline Calls	12 - 13
External Appeal Eligibility	14 - 15
Rejection of External Appeal Requests	16 - 17
Reversals by Health Plans	18 - 19
Certification of External Appeal Agents	20
External Appeal Agent Review	21
External Appeal Agent Decisions	22 - 23
External Appeal Results by Type of Health Plan Denial	24 - 25
Expedited External Appeals	26 - 27
External Appeal Results and Costs	28
External Appeal Decisions by Health Plan in 2005	29 - 31
External Appeal Decisions by Health Plan 1999 -2005	32 - 35
Disaster Planning and Preparation	36
Health Plan Surveys	37
State Survey	
State External Appeal Survey Results	38 - 39
Types of Denials Subject to External Appeal	40
Closing Remarks	41

Introduction

Recently completing its sixth year of operation, New York's External Appeal Program continues to provide New Yorkers with the right to obtain a review by independent medical experts when their health plan denies health care services as not medically necessary or because the plan considers the services to be experimental or investigational. The Program is the result of New York's landmark External Appeal Legislation which has proven to be an effective means of assisting consumers in gaining access to, and reimbursement for, health care services.

In order to be eligible for an external appeal, an insured, an insured's designee, or in certain cases, an insured's health care provider, must submit an external appeal request to the New York State Insurance Department within 45 days of receipt of a final adverse determination from a first level of appeal with a health plan, or upon waiver of the internal appeal process. The Insurance Department reviews requests for eligibility and completeness and randomly assigns appeals to one of three certified external appeal agents that have networks of medical experts available to review the appeal.

External appeal agents customarily assign one clinical peer reviewer to medical necessity appeals and three clinical peers to review appeals of treatments considered to be experimental or investigational. Decisions are rendered within thirty days for standard appeals, or within three days for expedited appeals if an attending physician attests that a delay would pose an imminent or serious threat to the health of the patient.

The New York State Insurance Department and the New York State Department of Health are responsible for oversight of the External Appeal Program and are statutorily required to review the activities of health plans and external appeal agents, investigate consumer complaints, and determine compliance with external appeal requirements. The law further provides that the Departments must annually report External Appeal Program results to the Legislature and Governor.

This year's report provides a comprehensive overview of the 2005 external appeal results, categorized by health plan, agent, and types of denials. As in previous years, the report also includes information about utilization review agents and federal developments impacting state external appeal programs.

- A brief overview of the report reveals that the number of external appeal requests submitted to the Insurance Department continues to steadily increase. In 2005, the number of external appeals increased 7% from 2004, and notably in 2004 the number of external appeals increased 29% from the previous year. In 2005, the Insurance Department received 2,475 external appeal requests, the highest number of requests since the Program's inception.
- In addition, the 2005 External Appeal Program results also show a slight increase in the percentage of medical necessity denials overturned in whole or in part by external appeal agents, while the experimental or investigational denials overturned in whole or in part by the agents decreased significantly.

Utilization Review Requirements and Agents that Contract with Health Plans

In order to be eligible for an external appeal, insureds must first appeal a denial through their health plan's internal utilization review appeal process. The utilization review process is used by health plans to determine whether services that have been provided, or are proposed to be provided, are medically necessary, experimental, or investigational. Common examples of utilization review determinations include the medical necessity of hospital admissions, the continuation of physical therapy visits or chiropractic care and the provision of surgical services.

Any health plan that conducts utilization review must have a utilization review procedure that complies with the requirements of Article 49 of the New York State Insurance Law and Public Health Law. In addition, health plans that provide coverage to employer groups and conduct utilization review are also required to comply with the U.S. Department of Labor Claims Payment Regulation (29 CFR Part 2560), which became effective July 1, 2002, and establishes minimum requirements for health plan claim procedures. The Department of Labor Claims Payment Regulation preempts state law to the extent that state law prevents the application of a federal requirement. The Insurance Department and the Health Department have been working with health plans to determine how health plans can best integrate the New York and federal requirements so that the plans will be in compliance with both.

Both New York law and the federal regulation require health plans to make utilization review determinations within prescribed timeframes depending on whether the health care services have been provided or whether urgent care is needed. New York law and the federal regulation also establish requirements as to how utilization review must be conducted and prescribe what information must be included in adverse determinations.

New York Insurance Law and Public Health Law require every health plan and utilization review agent performing utilization review on behalf of a health plan to file a report biennially with the Superintendent of Insurance and the Commissioner of Health, explaining their utilization plan and procedures. The health plan and utilization review agent must have a plan and procedures that, at a minimum, comply with the following requirements of Article 49 of the New York State Insurance Law and Public Health Law:

- Appoint a medical director, who is a licensed physician, or in certain circumstances a clinical director who is a licensed health care professional who typically manages the category of service. Responsibilities of the medical director, or, where appropriate the clinical director, shall include, but not be limited to, the supervision and oversight of the utilization review process.
- Develop written policies and procedures governing all aspects of the utilization review process.
- Make available to insureds and health care providers a written description of utilization review procedures, including procedures to appeal an adverse determination together with a description of the external appeal process.
- Utilize written clinical review criteria developed pursuant to a utilization review plan.
- Establish a process for rendering utilization review determinations that includes written procedures to assure that utilization reviews are conducted within established timeframes; procedures to notify an insured, an insured's designee and/or an insured's

health care provider of adverse determinations; and procedures for appeal of adverse determinations including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the insured.

- Establish written procedures to assure that notices of adverse determination include:
 - ✓ Reasons for the determination including the clinical rationale, if any;
 - ✓ Instructions on how to initiate standard and expedited appeals;
 - ✓ Notice of the availability, upon request of the insured or the insured's designee, of the clinical review criteria relied upon to make such determination;
- Establish a requirement that appropriate personnel are reasonably accessible by toll-free telephone not less than 40 hours per week during normal business hours.
- The utilization review agent must have a telephone system capable of accepting, recording or providing instruction to incoming telephone calls outside normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received OR not less than 40 hours per week during normal business hours, to discuss patient care and allow response to telephone requests.
- Establish appropriate policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed.
- Establish a requirement that emergency services rendered to an insured shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.

The Insurance Department surveyed health plans that had external appeals in 2005 to determine if the plans contract with utilization review agents and, if so, which services the agents review. The following chart lists health plans that contract with utilization review agents and identifies the types of services reviewed by utilization review agents. The chart groups health plans into categories based on the type of health insurance coverage provided:

- ✓ Health maintenance organizations (HMOs) contract with a network of doctors, hospitals and other types of providers to deliver a range of services to insureds. HMOs use primary care physicians as the coordinator of patient care needs and typically a referral must be obtained from the primary care physician before accessing specialty care.
- ✓ Non-profit indemnity insurers and commercial insurers are insurers that provide fee-for-service coverage so that the insured and the insurer pay a portion of the costs, which may be reduced if the insurer contracts with providers and the insured obtains services from a participating provider. The primary difference between these insurers is that commercial insurers are for-profit.

- ✓ Medicaid managed care plans are Prepaid Health Service Plans and HMOs that provide coverage to Medicaid recipients through a network of contracted providers. HMOs that provide coverage to both Medicaid recipients and other enrollees are included in the HMO chart below.
- ✓ Municipal Cooperative Health Benefit Plans are public entities, such as municipal corporations and school districts, that have joined together to share in the cost of self-funding health insurance coverage.

Health Maintenance Organizations	Name of Utilization Review Agent	Type of Service Reviewed
Aetna Health	<ul style="list-style-type: none"> • ACN Group (American Chiropractic Network) • CareCore National • Magellan Behavioral Health • Orthonet 	<ul style="list-style-type: none"> • Chiropractic • Radiology • Behavioral Health Services • Physical Therapy
Atlantis Health Plan	<ul style="list-style-type: none"> • ValueOptions 	<ul style="list-style-type: none"> • Behavioral Health
Capital District Physicians' Health Plan (CDPHP)	<ul style="list-style-type: none"> • St. Peter's Addiction Recovery Center • ValueOptions 	<ul style="list-style-type: none"> • Substance Abuse • Behavioral Health & Substance Abuse
CIGNA	<ul style="list-style-type: none"> • CIGNA Behavioral Health • Intracorp 	<ul style="list-style-type: none"> • Behavioral Health & Substance Abuse • Appeals
Empire HealthChoice	<ul style="list-style-type: none"> • Doral Dental (Child Health Plus Only) • Empire Contracted MD Consultants • Magellan Behavioral Health • MCMC Medical Care Management Corp. • National Imaging Associates (NIA) • Orthonet 	<ul style="list-style-type: none"> • Dental • Outside Specialty Reviews • Behavioral Health & Substance Abuse • Outside Specialty Reviews • Radiology • Physical Therapy & Speech Therapy
Excellus	<ul style="list-style-type: none"> • HealthPlex • Prism • VSP 	<ul style="list-style-type: none"> • Dental (Univera Community Health) • Chiropractic • Vision (Univera Health Care)
GHI HMO Select	<ul style="list-style-type: none"> • Alignis • CareCore National • Doral Dental • Express Scripts • Magellan Behavioral Health 	<ul style="list-style-type: none"> • Physical & Occupational Therapy • Radiology • Dental • Prescription Drugs • Behavioral Health

Health Insurance Plan of New York (HIP)	<ul style="list-style-type: none"> CareCore National CMO (Montefiore) Continuum Health MSO Health Care Partners Prism Health Networks Inspiris Lenox Hill Partners in Health 	<ul style="list-style-type: none"> Radiology Hospital Hospital Hospital Chiropractic Hospital Hospital Hospital
Health Net of New York	<ul style="list-style-type: none"> CareCore National CareGuide Landmark Healthcare Managed Health Network (MHN) Health Net Pharmaceutical Services, Inc. (HNPS) 	<ul style="list-style-type: none"> Radiology Home Care & Skilled Nursing Facilities Chiropractic Behavioral Health Pharmacy
HealthNow New York, Inc.	<ul style="list-style-type: none"> National Imaging Associates (NIA) Prism Health Networks 	<ul style="list-style-type: none"> Radiology Chiropractic
Independent Health	<ul style="list-style-type: none"> National Imaging Associates (NIA) 	<ul style="list-style-type: none"> Radiology
MVP Health Plan	<ul style="list-style-type: none"> MCMC Medical Care Management Corp. 	<ul style="list-style-type: none"> Outside Specialty Reviews
Oxford	<ul style="list-style-type: none"> CareCore National Orthonet TRIAD Healthcare 	<ul style="list-style-type: none"> Radiology Physical Therapy Chiropractic
Preferred Care	<ul style="list-style-type: none"> PREST Associates 	<ul style="list-style-type: none"> Behavioral Health
United Healthcare of New York	<ul style="list-style-type: none"> MCMC Medical Care Management Corp. Medical Review Institute National Medical Review 	<ul style="list-style-type: none"> Medical/Surgical Benefits Medical/Surgical Benefits Medical/Surgical Benefits
Vytra Health Plans	<ul style="list-style-type: none"> Prism Health Networks 	<ul style="list-style-type: none"> Chiropractic

Non-Profit Indemnity Insurers	Name of Utilization Review Agent	Type of Service Reviewed
Excellus	<ul style="list-style-type: none"> HealthPlex Prism VSP 	<ul style="list-style-type: none"> Dental (Univera Community Health) Chiropractic Vision (Univera Health Care)
Group Health, Inc.	<ul style="list-style-type: none"> Alignis/American Whole Health CareCore National Doral Dental IMEDECS MCMC Medical Care Management Corp. ValueOptions 	<ul style="list-style-type: none"> Chiropractic and Physical Therapy Radiology Dental Medical, Surgical & Behavioral Health & Substance Abuse Medical, Surgical & Behavioral Health & Substance Abuse Behavioral Health and Substance Abuse

HealthNow New York, Inc.	<ul style="list-style-type: none"> • National Imaging Associates (NIA) • Prism Health Networks 	<ul style="list-style-type: none"> • Radiology • Chiropractic
--------------------------	--	---

Commercial Insurers	Name of Utilization Review Agent	Type of Service Reviewed
Aetna Group	<ul style="list-style-type: none"> • ACN Group (American Chiropractic Network) • CareCore National • Magellan Behavioral Health • Orthonet 	<ul style="list-style-type: none"> • Chiropractic • Radiology • Behavioral Health Services • Physical Therapy
CIGNA Health Group	<ul style="list-style-type: none"> • CIGNA Behavioral Health • Intracorp 	<ul style="list-style-type: none"> • Behavioral Health & Substance Abuse • Appeals
Empire HealthChoice	<ul style="list-style-type: none"> • Empire Contracted MD Consultants • Magellan Behavioral Health • MCMC Medical Care Management Corp. • National Imaging Associates (NIA) • Orthonet 	<ul style="list-style-type: none"> • Outside Specialty Reviews • Behavioral Health & Substance Abuse • Outside Specialty Reviews • Radiology • Physical Therapy & Speech Therapy
GE Assurance Company	<ul style="list-style-type: none"> • Medical Review Institute (MRI) • Private Health Care Systems (PHCS) 	<ul style="list-style-type: none"> • Chiropractic, Physical Therapy and Dental • Hospital & Medical
Guardian Life Group	<ul style="list-style-type: none"> • Private Health Care Systems (PHCS) 	<ul style="list-style-type: none"> • Hospital & Medical
Horizon Healthcare Insurance Company of New York	<ul style="list-style-type: none"> • Caremark • Greenspring Healthcare Services • National Imaging Associates (NIA) 	<ul style="list-style-type: none"> • Pharmacy • Behavioral Health • Radiology
New England Life Insurance	<ul style="list-style-type: none"> • Private Health Care Services (PHCS) 	<ul style="list-style-type: none"> • All Utilization Review
Nippon Life Insurance Company	<ul style="list-style-type: none"> • Principal Life Insurance Company 	<ul style="list-style-type: none"> • All Utilization Review
Oxford Health Insurance	<ul style="list-style-type: none"> • CareCore National • Orthonet • TRIAD Healthcare 	<ul style="list-style-type: none"> • Radiology • Physical Therapy • Chiropractic
PerfectHealth Insurance Co.	<ul style="list-style-type: none"> • Healthcare Strategies 	<ul style="list-style-type: none"> • All Utilization Review
Trustmark Insurance Company	<ul style="list-style-type: none"> • Private Health Care Services (PHCS) 	<ul style="list-style-type: none"> • All Utilization Review
Unicare Life & Health	<ul style="list-style-type: none"> • Cost Care, Inc. 	<ul style="list-style-type: none"> • All Utilization Review
Union Labor Life Insurance Company	<ul style="list-style-type: none"> • Alicare Medical Management, Inc. 	<ul style="list-style-type: none"> • All Utilization Review

Medicaid Managed Care Plans	Name of Utilization Review Agent	Type of Service Reviewed
Affinity Health Plan	<ul style="list-style-type: none"> • Beacon Health Strategies • Block Vision • HealthPlex • NMHC Rx 	<ul style="list-style-type: none"> • Behavioral Health & Substance Abuse • Vision • Dental • Pharmacy
Community Health Choice	<ul style="list-style-type: none"> • DST • CCHP 	<ul style="list-style-type: none"> • Vision, Hospital & Medical • Dental, Behavioral Health & Transportation
Healthfirst, Inc.	<ul style="list-style-type: none"> • ACN Group (American Chiropractic Network) • CareCore National • Davis Vision • Doral Dental • ESI • University Behavioral Health 	<ul style="list-style-type: none"> • Chiropractic • Radiology • Vision • Dental • Pharmacy • Behavioral Health
HealthNow New York, Inc.	<ul style="list-style-type: none"> • National Imaging Associates (NIA) • Prism Health Networks 	<ul style="list-style-type: none"> • Radiology • Chiropractic
Health Plus	<ul style="list-style-type: none"> • Health Plex 	<ul style="list-style-type: none"> • Dental
Hudson Health Plan	<ul style="list-style-type: none"> • Beacons Health Strategies 	<ul style="list-style-type: none"> • Behavioral Health
Senior Health Partners	<ul style="list-style-type: none"> • Healthplex 	<ul style="list-style-type: none"> • Dental
WellCare	<ul style="list-style-type: none"> • Health Integrated • Healthplex 	<ul style="list-style-type: none"> • Behavioral Health • Dental

Municipal Cooperative Health Benefit Plans	Name of Utilization Review Agent	Type of Service Reviewed
Putnam/Northern Westchester Health Benefits Consortium	<ul style="list-style-type: none"> • Aetna Life Insurance Company 	<ul style="list-style-type: none"> • All Utilization Review
State-Wide Schools Cooperative Health Plan	<ul style="list-style-type: none"> • Empire Contracted MD Consultants • Magellan Behavioral Health • MCMC Medical Care Management Corp. • NIA • Orthonet 	<ul style="list-style-type: none"> • Specialty Reviews • Behavioral Health & Substance Abuse • Outside Specialty Reviews • MRAs & MRIs • Physical, Occupational, & Speech Therapy

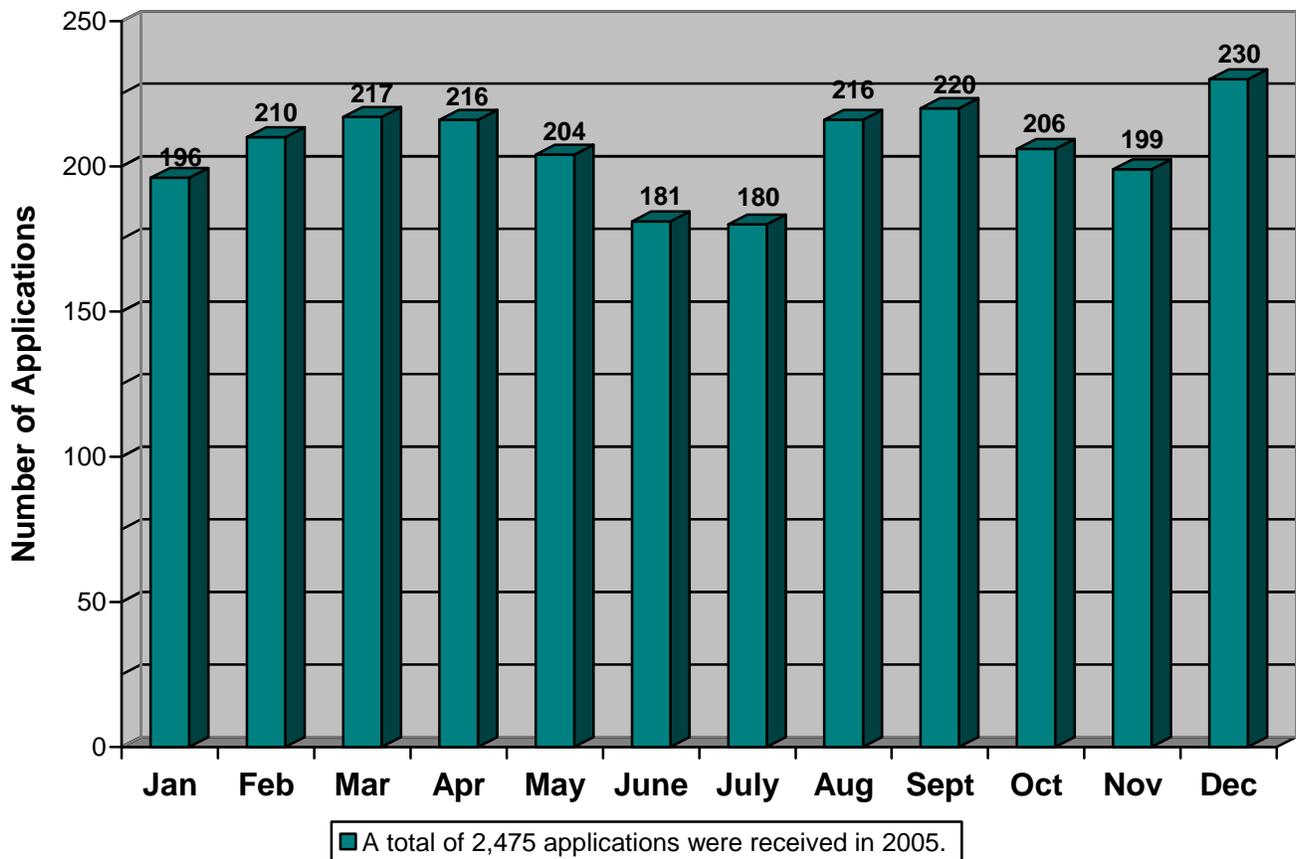
Volume of External Appeal Requests Received by the Insurance Department

When a health plan makes a utilization review determination that services are not medically necessary or are experimental or investigational, the External Appeal Law gives health care consumers the right to obtain an independent review of the determination. Consumers may request an external review by submitting an application to the Insurance Department. The Insurance Department has received 11,804 applications since the inception of the External Appeal Program in July, 1999 through 2005.

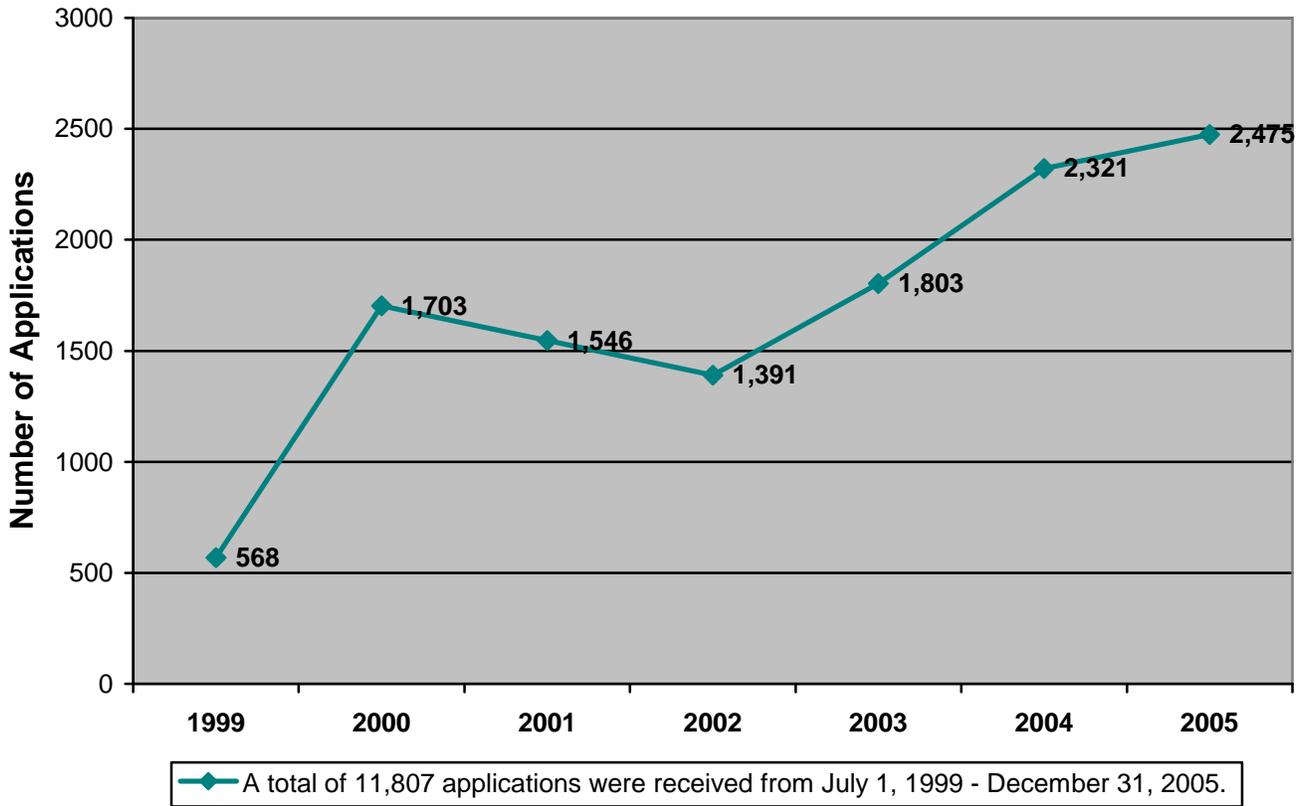
- In 2005, the Department received 2,475 external appeal applications, the largest number of requests since the program's inception, and a 7% increase over 2004.
- In 2004, the Department received 2,321 applications, a 29% increase over 2003.
- In 2003, the Department received 1,803 applications, a 30% increase over 2002.
- In 2002, the Department received 1,391 applications, a 10% decrease from 2001.
- In 2001, the Department received 1,546 applications, a 10% decrease from 2000.
- In 2000, the first full year of operation of the External Appeal Program, the Department received 1,703 applications.

The following charts identify the number of external appeal requests submitted to the Insurance Department each month in 2005 and the number submitted since the program's inception.

**External Appeal Applications Received by the Insurance Department
in 2005**



**Total External Appeal Applications Received
July 1, 1999 - December 31, 2005**

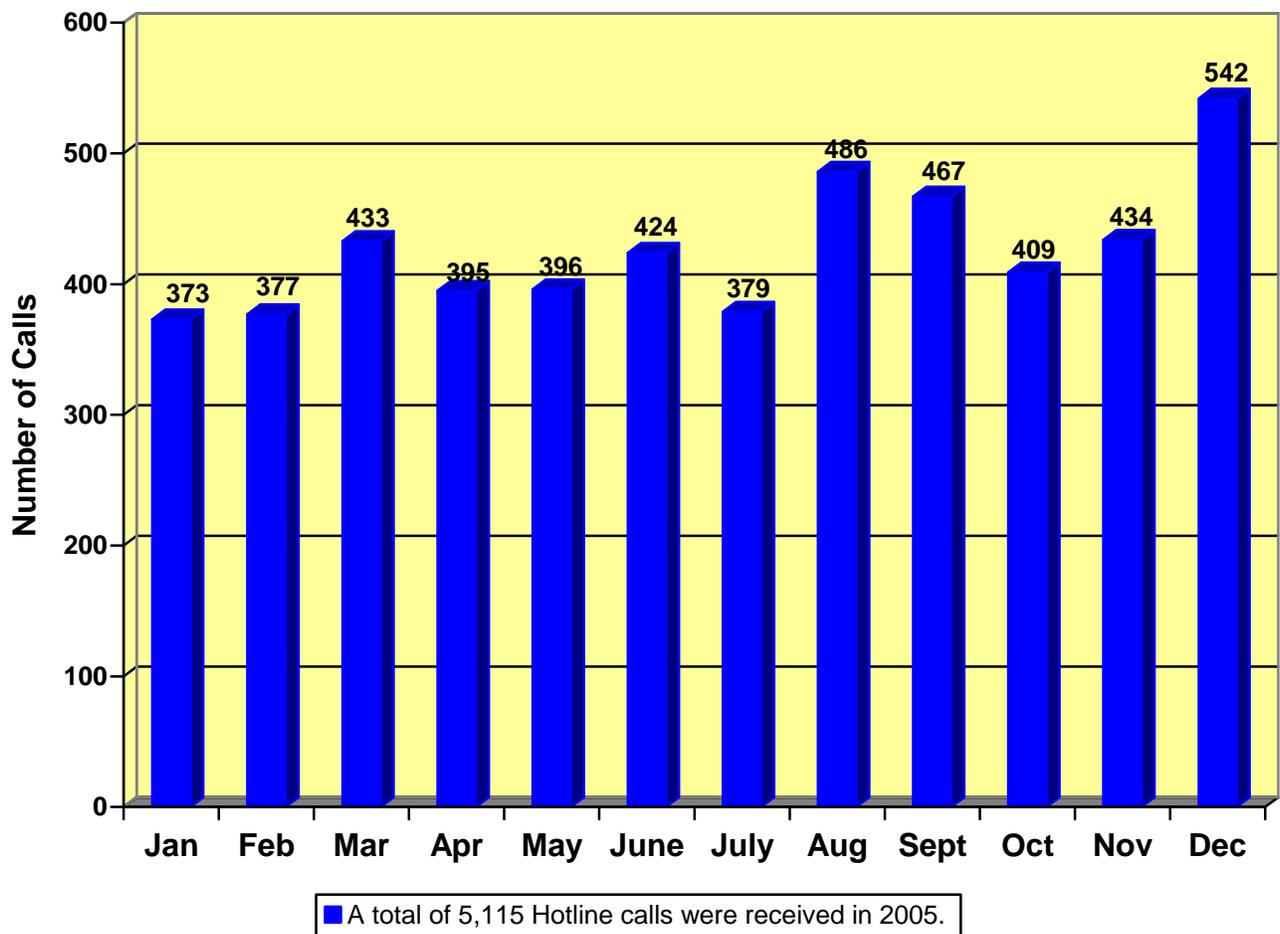


Volume of External Appeal Hotline Calls

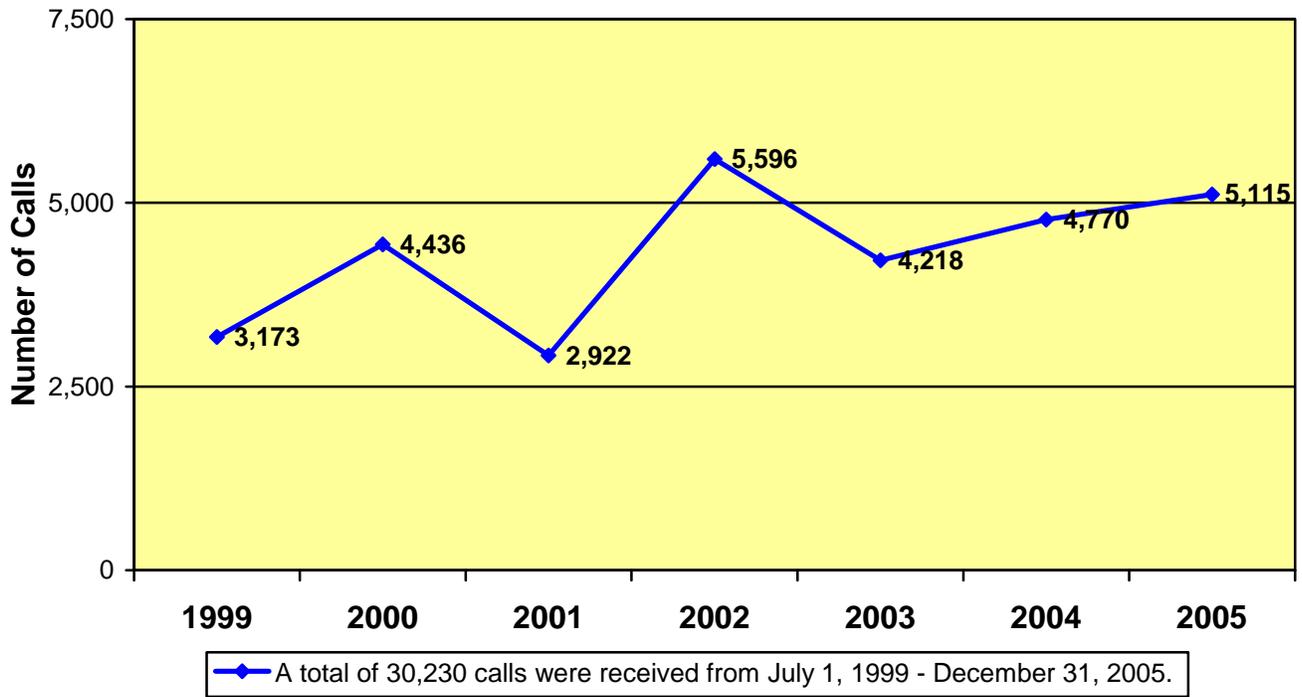
The Insurance Department operates an external appeal hotline (1-800-400-8882) to assist consumers in utilizing their external appeal rights. Hotline operators answer any external appeal questions consumers may have and assist consumers in submitting external appeal requests. The hotline is operated by trained and experienced staff from the Insurance Department's Consumer Services Bureau, with back-up assistance provided by attorneys in the Department's Health Bureau. The hotline is staffed Monday through Friday from 9:00 a.m. – 5:00 p.m. If a consumer calls after hours, a message can be left with the answering service that will be responded to the next business day.

The Insurance Department has received and responded to over 30,000 hotline calls since the hotline became operational. The following chart identifies the number of external appeal calls received by the Insurance Department on a monthly basis from January 2005 through December 2005.

Incoming Calls to the Toll-Free External Appeal Hotline in 2005



**Total Incoming Calls to the Toll-Free Hotline
July 1, 1999 - December 31, 2005**



External Appeal Eligibility

The Insurance Department is responsible for reviewing external appeal applications for eligibility and completeness and for assigning eligible requests to external appeal agents. The Department's review must be conducted within 24 hours of receipt if the appeal is expedited or within five business days of receipt if the appeal is standard. The Insurance Department considers an external appeal request to be eligible if the following conditions are met:

- **Applicability:**

- ✓ Services must have been denied as not medically necessary or as experimental or investigational. Other types of coverage determinations, such as a denial because the insured has a pre-existing condition, the benefit is not covered under the insurance policy, or the insured is requesting a referral to a non-participating provider, are not eligible for external appeal.
- ✓ The insured must be covered under a fully insured health insurance contract issued in New York State. The External Appeal Law is not applicable to self-insured coverage, health insurance contracts issued outside of New York, Medicaid fee-for-service coverage, and Medicare coverage, including coverage provided by Medicare managed care plans. Persons covered under Medicaid are eligible for the Fair Hearing Process and persons covered under Medicare are eligible for a Medicare appeals process.

- **Timeliness:**

- ✓ An external appeal application must be submitted to the Insurance Department within 45 days of receipt of the final adverse determination from the first level of internal appeal with a health plan or receipt of notice that the health plan agreed to waive the internal appeal process.
- ✓ The Insurance Department presumes that the final adverse determination was received within 8 days of the date on the determination, unless otherwise demonstrated, so that the applicant has 53 days (45 plus an additional 8 days) to initiate an external appeal.

- **Completeness:**

- ✓ The application must be signed. The patient, a parent if the patient is a minor, a guardian, or if the patient is deceased, the administrator or executor of a patient's estate, must sign the application.
- ✓ A copy of the final adverse determination must be included with the external appeal request.
- ✓ If services were denied as experimental or investigational, the patient's attending physician must complete the attestation portion of the external appeal application and attach two articles of medical and scientific evidence. If the appeal is for a clinical trial, it is also recommended that the physician submit the clinical trial protocols.

- ✓ If an expedited appeal is requested, the patient's attending physician must complete the attestation portion of the external appeal application and affirm that the patient has not received the requested service and that a delay would pose an imminent or serious threat to the health of the patient.

- ✓ The \$50.00 external appeal fee must be submitted, if required by the health plan. The fee is automatically waived for insureds covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee would pose a hardship. The fee is returned to the applicant if the external appeal agent overturns the health plan's denial in whole or in part, or forwarded to the health plan if the denial is upheld.

Rejection of External Appeal Requests

External appeal requests that are statutorily ineligible for external appeal are rejected by the Insurance Department and returned to the applicant. An external appeal request will be rejected for the following reasons:

- If services were not denied on the basis of medical necessity or because the services were considered experimental or investigational.
- If the insured has coverage that is exempt from the New York external appeal requirements, such as self-insured coverage, Medicaid fee-for-service coverage, or Medicare coverage.
- If the insured does not submit an application within the 45 day time frame for requesting an external appeal.
- If an external appeal application is incomplete and the missing information is not provided to the Insurance Department after two requests are made for the information.
 - ✓ An external appeal application is considered to be incomplete if:
 - ◆ the application is not signed;
 - ◆ the final adverse determination is not provided;
 - ◆ a fee is required and is not submitted; or,
 - ◆ the appeal is for experimental or investigational services and the attending physician attestation has not been completed.
 - ✓ If an application is incomplete, the Insurance Department will request the missing information from the applicant and, as appropriate, from the applicant's attending physician, and allow two weeks for a response.
 - ✓ If a response is not provided, the Insurance Department will make a second request for the information. If a response is not provided to the second request, the application will be rejected.

When an application is rejected, the applicant is advised that although the request is ineligible for external appeal, the Insurance Department's Consumer Services Bureau is available to investigate the health plan's denial, and will do so upon the applicant's request. If federal law applies to the applicant's coverage instead of New York law, the Insurance Department will also provide information on Medicare appeal rights or rights under self-insured plans, as applicable.

Since the beginning of the external appeal program in July 1999, 3,224 external appeal requests have been rejected as ineligible for external appeal. Fewer applications were rejected in 2005 than in 2004, as 668 external appeal requests were rejected in 2005, compared with 678 requests in 2004. The most frequent reason for rejection of external appeal requests has been that the application is incomplete and the applicant did not provide the missing information after two requests were made by the Insurance Department. However, in 2004, there was also a significant increase in the number of requests rejected because the application was not submitted within the 45 day timeframe. In fact, over half of the rejected applications in 2004 and 2005 were rejected because they were incomplete or untimely.

The following chart identifies the number of external appeal requests that have been rejected in New York in 2004 and 2005 and lists the reasons for rejection.

Reasons for Rejection of External Appeal Requests in New York		
	2005	2004
Applicant did not provide one or more of the following: <ul style="list-style-type: none"> Physician attestation for experimental/investigational appeal. Health plan denial letter. Check or money order. Patient did not submit external appeal request and did not confirm interest in pursuing an external appeal. Consent form. An application. 	178	192
Application was not submitted within the 45 day time frame.	159	158
Applicant did not first appeal the denial with the health plan.	53	62
Self-insured coverage.	74	58
Provider ineligible to request an external appeal.	58	53
Denial was for a benefit that was not covered under the contract.	55	49
CPT code, UCR, or level of reimbursement dispute.	23	26
Denial for a referral to a non-participating provider.	15	24
Applicant withdrew external appeal request.	20	18
Out-of-state insurance policy.	12	12
Duplicate applications submitted.	6	6
Attending physician attestation for experimental/investigational appeal did not meet the requirements of law.	4	5
Complaints relating to eligibility, termination, premiums, and administration of contract.	0	5
Medicare managed care coverage.	8	5
Federal employee coverage or United States military coverage.	1	3
Denial for a failure to request pre-authorization.	1	1
Worker's compensation claim.	0	0
Member pursued a Medicaid Fair Hearing instead of an external appeal.	0	0
Total	667	677

Reversals by Health Plans

An appeal may also be closed during the external appeal process because a health plan reverses its adverse determination before a decision is rendered by an external appeal agent. Some denials are reversed by a health plan when an external appeal is initially requested, while others are reversed because new information is submitted with the external appeal request.

From the program's inception in July 1999 through December 31, 2005, 12% of all appeals received were closed during the appeal process because a health plan reversed its adverse determination before the external appeal agent rendered a determination. In the past two years, 291 appeals were reversed in 2004 and 220 appeals were reversed in 2005.

Health Maintenance Organizations	Health Plan Reversals in 2005	Health Plan Reversals in 2004
Aetna Health	4	3
Atlantis Health Plan	4	6
Capital District Physicians' Health Plan (CDPHP)	9	6
CIGNA	3	6
Empire HealthChoice	21	12
Excellus (Rochester)	2	2
Excellus (Utica Watertown)	1	3
Excellus (Univera)	2	2
GHI HMO Select	1	1
Health Insurance Plan of Greater NY (HIP)	0	6
Health Net of New York	9	3
HealthNow New York, Inc.	12	21
Independent Health	1	0
MDNY	1	0
MVP Health Plan	2	3
Oxford	44	100
Rochester Area HMO (Preferred Care)	1	1
Vytra Health Plans	2	0
Total	119	175

Non-Profit Indemnity Insurers	Health Plan Reversals in 2005	Health Plan Reversals in 2004
Excellus Health Plan, Inc. (CNY)	3	6
Excellus Health Plan, Inc. (Rochester)	2	0
Excellus Health Plan, Inc. (Utica Watertown)	1	0
Group Health, Inc.	28	58
HealthNow New York, Inc.	1	8
Total	35	72

Commercial Insurers	Health Plan Reversals in 2005	Health Plan Reversals in 2004
Aetna Group	1	1
CIGNA Health Group	1	1
Empire HealthChoice Assurance	20	22
GE Global Group	1	0
Guardian Life Group	1	0
Guardian Life Group (Dental)	2	1
Horizon Healthcare Insurance Company of New York	10	4
Metropolitan Group	5	2
Mutual of Omaha Group	0	1
Oxford Health Insurance	1	0
United HealthCare Insurance Company of New York	6	4
Total	48	36

Medicaid Managed Care Plans	Health Plan Reversals in 2005	Health Plan Reversals in 2004
Affinity Health Plan	1	0
AmeriChoice	2	0
CenterCare	1	0
Community Premier Plus, Inc.	1	0
Fidelis Care New York	5	1
Healthfirst, Inc.	1	0
MetroPlus Health	3	4
Neighborhood Health Providers	0	1
New York Presbyterian Community Health Plan	2	0
United Healthcare of New York	2	0
Total	18	6

Municipal Cooperative Health Benefit Plans	Health Plan Reversals in 2005	Health Plan Reversals in 2004
Jefferson-Lewis School Employees Health Care Plan	0	1
Orange-Ulster School District Health Plan	0	1
Total	0	2

Certification of External Appeal Agents

External appeal agents are certified by the Insurance Department and the Health Department for two-year periods and must meet the following certification standards:

- External appeal agents must have a comprehensive network of clinical peer reviewers available to review a health plan's denial of services.
- Clinical peer reviewers must be appropriately licensed and trained in New York external appeal standards.
- External appeal agents must assign appeals to a clinical peer in the same or similar specialty as the health care provider that typically manages the medical condition or provides the treatment that is the subject of the appeal, so that cases will be reviewed by a qualified and impartial provider in the appropriate specialty.
- External appeal agents must appoint a medical director who is responsible for oversight of the external appeal process.
- External appeal agents must have policies and procedures in place to protect confidentiality and must have a quality assurance program.
- External appeal agents must have mechanisms in place to ensure that appeal decisions are made within the required time frames.
- External appeal agents and clinical peer reviewers must be independent from the health plan and any party involved in the appeal so that there is no conflict of interest. External appeal agents and their clinical peer reviewers are prohibited from having a material professional affiliation, a material financial affiliation, or a material familial affiliation with the health plan, insured, provider, or facility involved in the external appeal. External appeal agents are also prohibited from accepting an appeal if they previously reviewed the case in connection with the health plan's internal appeal procedure.

Currently there are three certified external appeal agents that review external appeals in New York. The agents are Medical Care Management Corporation (MCMC), certified on July 2, 1999, recertified on July 1, 2001, July 1, 2003, and July 1, 2005; Island Peer Review Organization (IPRO), certified on June 30, 1999, recertified on July 1, 2001, July 1, 2003, and July 1, 2005; and Independent Medical Expert Consulting Services, Inc. (IMEDECS) formerly known as Hayes Plus, certified on June 21, 2001, and recertified on July 1, 2003, and July 1, 2005. As part of the recertification process, each of the agents must provide a description of any policies and procedures that have changed since the previous certification, along with a description of any changes in the agent's network of clinical peer reviewers. The agents must also provide a plan of correction for any deficiencies the Departments identify during the recertification process.

External Appeal Agent Review

The standard of review that an external appeal agent utilizes when assigned to a particular case is established by law and varies depending on whether services have been denied as not medically necessary, experimental, investigational, or because the services are provided in a clinical trial. When reviewing a medical necessity denial, an external appeal agent must make a determination as to whether the health plan acted reasonably, with sound medical judgement and in the best interest of the patient. An external appeal agent must consider the clinical standards of the plan, the information provided concerning the patient, the attending physician's recommendation, and applicable and generally accepted practice guidelines.

When reviewing an appeal of experimental or investigational services, an external appeal agent must consider the medical and scientific evidence, the patient's medical record and any other pertinent information and determine whether the proposed service is likely to be more beneficial than any standard treatment. If the appeal involves a clinical trial, an external appeal agent must review the patient's medical record and any other pertinent information and determine whether the clinical trial is likely to benefit the patient. Typically, external appeal agents assign one clinical peer to review medical necessity denials and three clinical peers to review appeals of experimental or investigational treatments.

If a patient's attending physician attests that a delay would pose an imminent or serious threat to the health of the patient, the appeal will be expedited, and the agent must issue a decision in three days. If the appeal is not expedited, the external appeal agent must issue a decision within 30 days, unless the agent needs additional information, and then the agent will have five additional business days to render a determination.

An external appeal agent must notify the health plan, the patient, and as appropriate, the patient's provider of the determination by telephone or facsimile if the appeal is expedited, with written notification to follow. If the appeal is not expedited, notification must be provided in writing within two days from when the decision is rendered. The decision of the external appeal agent is subject to the terms and conditions of the patient's coverage with the health plan, such as cost sharing requirements or maximum visit limits. The decision of the external appeal agent is also binding on the parties, and admissible in court proceedings.

The Insurance Department is responsible for reviewing complaints from patients, providers and health plans in relation to external appeal agent determinations. The Department investigates all complaints to ensure the appeal was conducted in compliance with statutory and regulatory requirements. In 2005, the Department received 62 complaints, a decrease from the 75 complaints received in 2004. The types of complaints most frequently received are disagreement with the external appeal agent's decision or with the Department's rejection of an external appeal application.

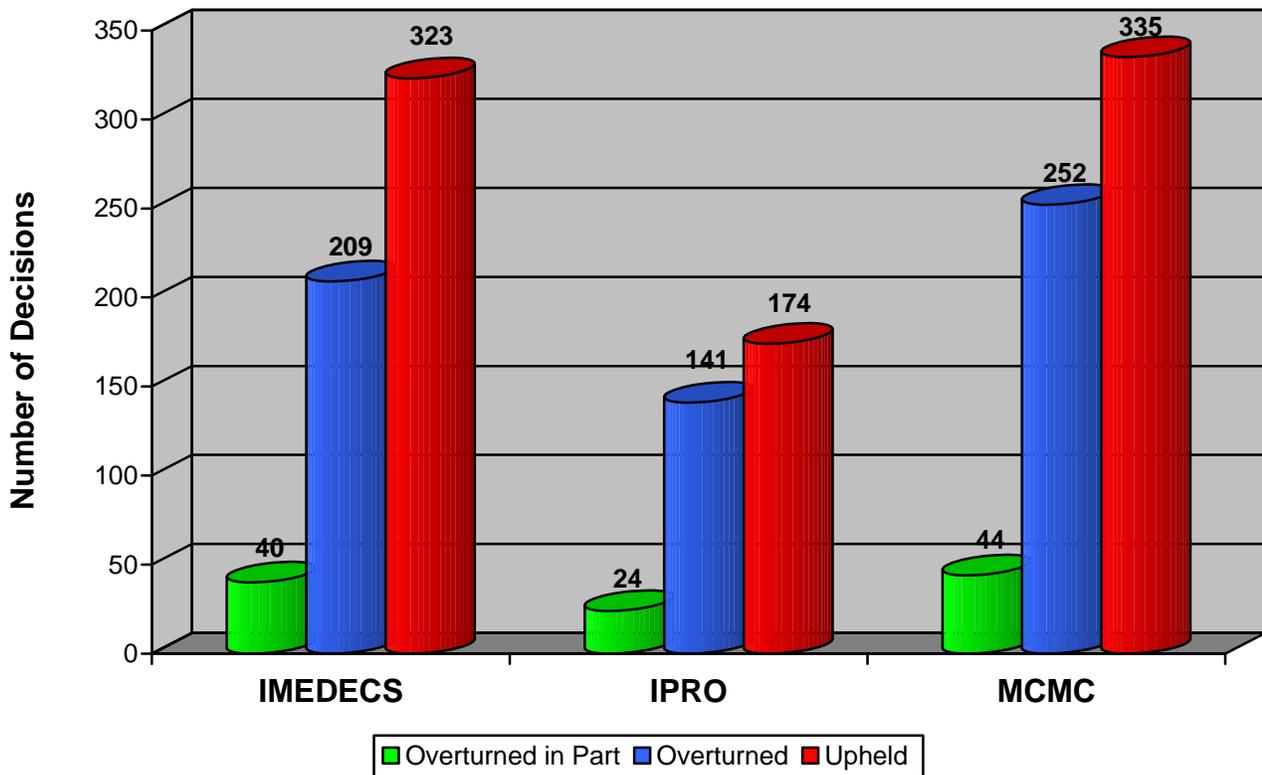
External Appeal Agent Decisions

The Insurance Department randomly assigns appeals to external appeal agents and provides all information submitted with the application to the agent once the Department verifies that the agent does not have a conflict of interest with respect to the appeal.

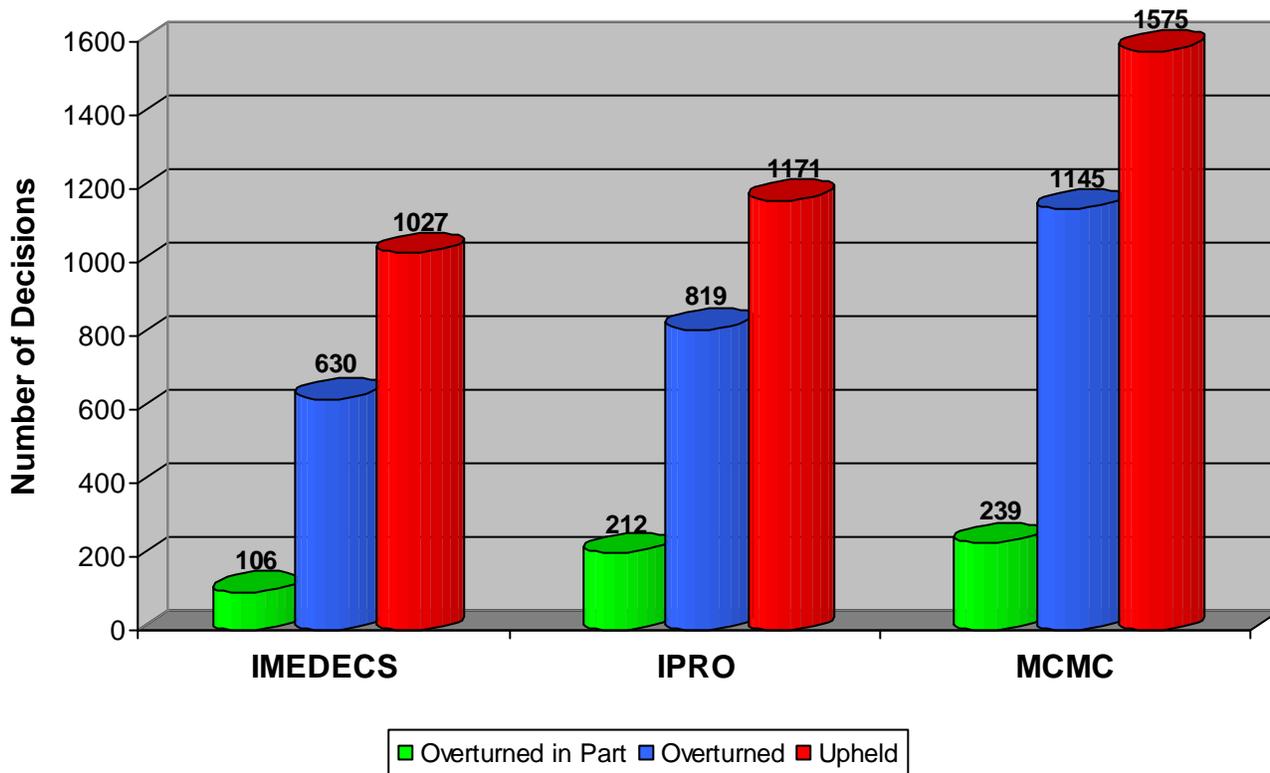
- In 2005, 572 cases were assigned to IMEDECS, 339 were assigned to IPRO, and 631 were assigned to MCMC. The health plan denials were overturned in whole or part by IMEDECS in 44% of cases, by IPRO in 49% of cases, and by MCMC in 47% of cases. The differences in case assignments can be attributed to the random assignment process and to reassignments due to conflicts of interest.
- In 2004, health plan denials were overturned in whole or in part by IMEDECS in 42% of cases, by IPRO in 47% of cases, and by MCMC in 47% of cases.
- In 2003, health plan denials were overturned in whole or in part by IMEDECS in 40% of cases, by IPRO in 40% of cases and by MCMC in 50% of cases.

The first chart identifies external appeal results by agent from July 1999 through December 2005. The second chart identifies external appeal results by agent for 2005.

External Appeal Decisions by Agent 2005



**External Appeal Decisions by Agent
July 1, 1999 - December 31, 2005**



External Appeal Results by Type of Health Plan Denial

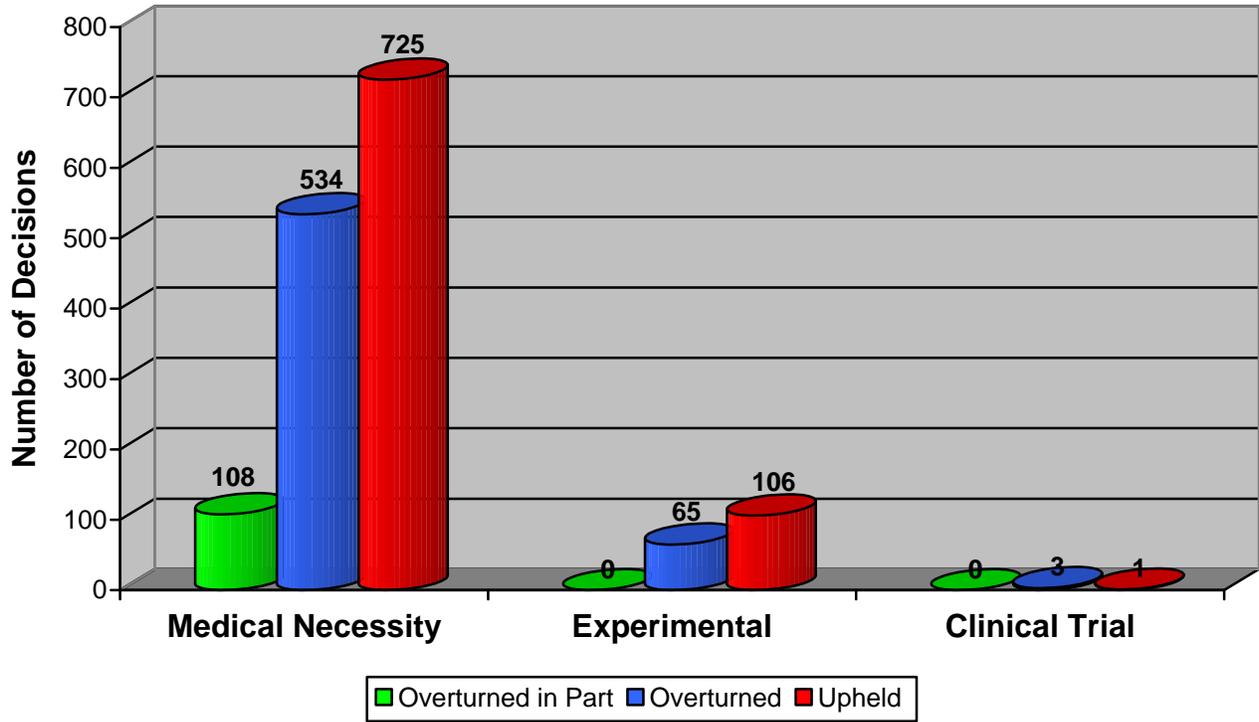
Since the beginning of the External Appeal Program, through the most recent year, the majority of external appeal requests have related to denials based on medical necessity, as opposed to denials because services were considered experimental or investigational. Of the medical necessity denials, the most frequent types of services appealed in 2005 included surgical services, inpatient hospital services, diagnostic testing, durable medical equipment, mental health services, physical therapy, prescription drug coverage, and chiropractic services.

In 2005, the percentage of medical necessity denials overturned increased slightly, yet the percentage of experimental or investigational denials overturned decreased significantly.

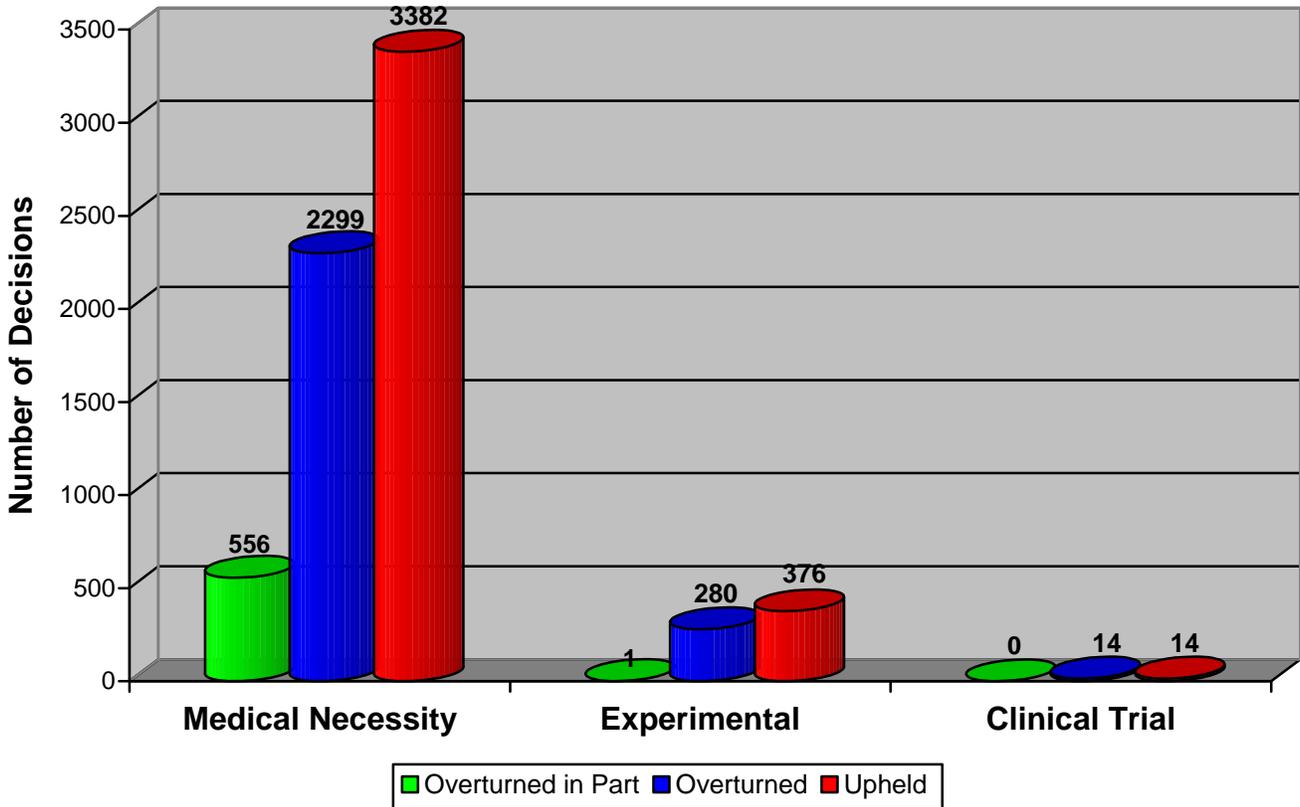
- In 2005, 47% of medical necessity denials were overturned in whole or in part, while 38% of experimental or investigational treatment denials were overturned.
- In 2004, 45% of medical necessity denials were overturned in whole or in part, while 51% of experimental or investigational treatment denials were overturned.
- In 2003, 42% of medical necessity denials were overturned in whole or in part, while 50% of experimental or investigational treatment denials were overturned.

The following charts identify external appeal results based on whether services were denied as not medically necessary or as experimental or investigational:

**External Appeal Decisions by Type of Health Plan Denial
2005**



External Appeal Decision by Type of Health Plan Denial 1999-2005



Expedited External Appeals

An external appeal must be expedited if the patient's attending physician attests that a delay in providing the health care service would pose an imminent or serious threat to the health of the patient. If an appeal is expedited, the law requires the external appeal agent to make a decision in three days instead of the standard 30 days.

Expedited external appeals can be problematic because the three day timeframe only allows the patient and the patient's health care provider a limited opportunity to submit additional information. Due to this time constraint, the external appeal agent can have difficulty obtaining this information in the short timeframe, especially if the appeal is submitted over the weekend. Thus, it is essential for the patient's provider to immediately forward the patient's medical records to the external appeal agent, as the law requires the external appeal agent to issue a decision in three days, regardless of whether the agent has all the necessary information.

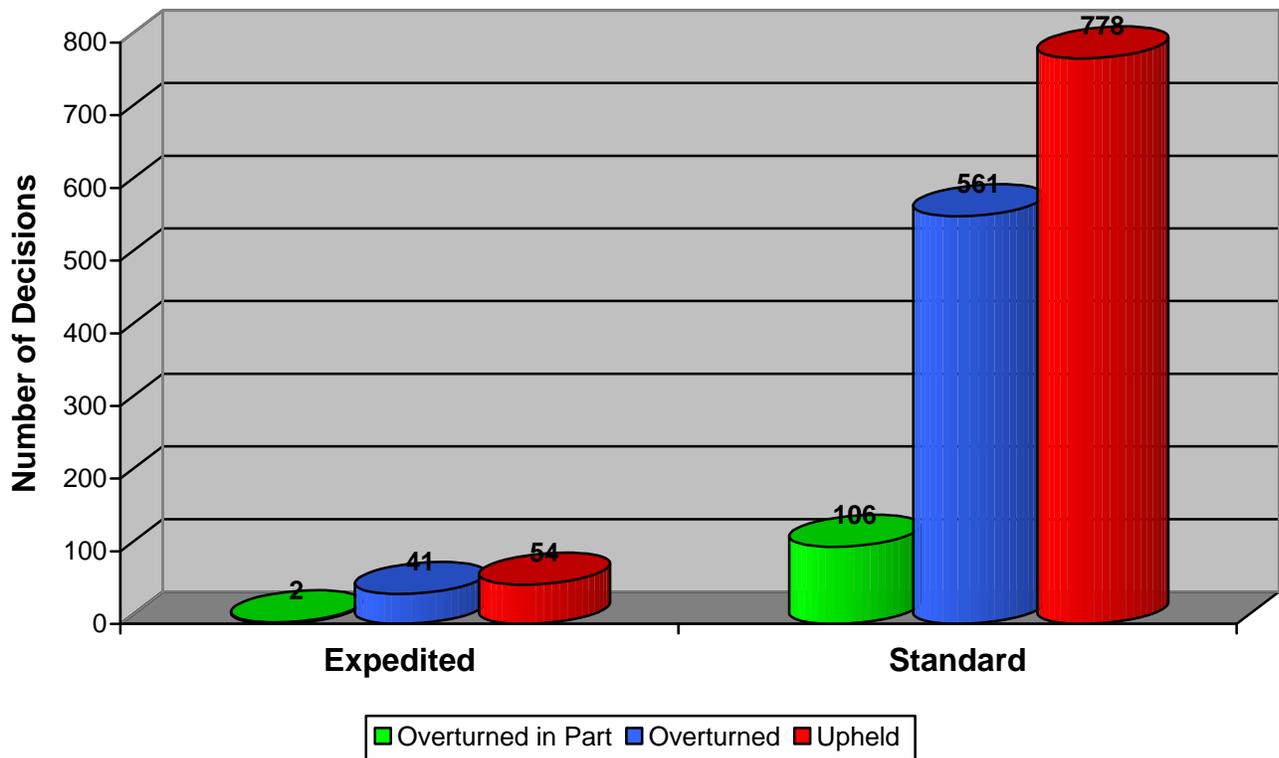
Insurance Department staff is available to handle expedited appeals submitted during business hours and after the close of business. Two Insurance Department staff members are on call each weekend to handle expedited appeals. Applicants requesting an expedited appeal are asked to call the Department to provide notice that an expedited appeal is being submitted.

Since the beginning of the external appeal program, 430 expedited appeals have been reviewed by external appeal agents, which represents 6.2% of all appeals reviewed by external appeal agents. The number of expedited external appeals reviewed has increased slightly each year.

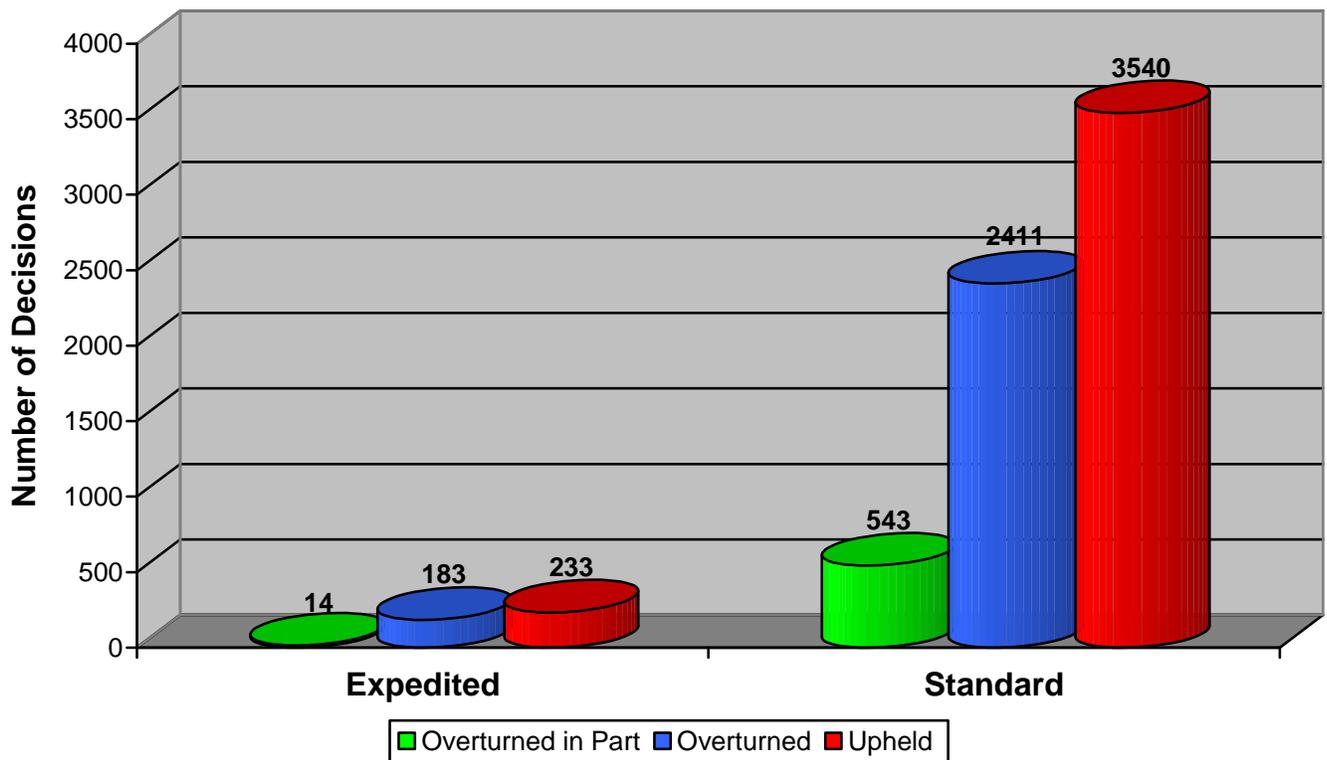
- In 2005, 97 expedited external appeals were reviewed by the external review agents, or 6.3% of the total external appeals reviewed.
- In 2004, 89 expedited external appeals were reviewed by the external review agents, or 6.5% of the total external appeals reviewed.
- In 2003, 62 expedited external appeals were reviewed by the external review agents, or 5.9% of the total external appeals reviewed.
- In 2002, 48 expedited external appeals were reviewed by the external review agents, or 5.5% of the total external appeals reviewed.

The first chart compares standard and expedited appeal results for 1999 – 2005 and the second chart compares standard and expedited appeal results for 2005. In 2005, the percentage of expedited appeals overturned in whole or in part by external appeal agents was 44%, slightly less than the 46% of standard appeals overturned by external appeal agents.

External Appeal Decisions by Type of Appeal 2005



External Appeal Decision by Type of Appeal
July 1, 1999 - December 31, 2005



External Appeal Results and Costs

In addition to viewing external appeal results by agent, by type of health plan denial, and by type of appeal, external appeal results can also be viewed on a calendar year basis. As seen in the chart below, there have been a total of 6,924 decisions rendered by external appeal agents since the beginning of the External Appeal Program in July 1999 through 2005. The overall percentage of health plan denials overturned in whole or in part by external appeal agents declined slightly in 2001 through 2003 and increased in 2004 and again in 2005.

Timeframe	Total	Health Plan Denial Overturned	Health Plan Denial Overturned in Part	Health Plan Denial Upheld	Percentage Overturned in Whole or in Part
1999	205	79	20	106	48.3%
2000	936	371	91	474	49.4%
2001	946	347	76	523	44.7%
2002	878	309	80	489	44.3%
2003	1053	373	76	604	42.6%
2004	1364	513	106	745	45.4%
2005	1542	602	108	832	46.0%
Total	6924	2594	557	3773	45.5%

Health plans are responsible for paying the external appeal agent for the appeal regardless of whether the health plan's determination is upheld or overturned. The fees charged by external appeal agents are approved by the Insurance Department and the Health Department for two year periods. The fees must be reasonable, and must be inclusive of indirect costs, administrative fees and incidental expenses. A health plan must pay the external appeal agent's fee within 45 days from the date the appeal determination is received by the health plan. If payment is not made within the 45 days, the plan is required to pay the agent interest at a statutorily prescribed rate. Below is a table of the costs to all health plans for external appeal determinations rendered in 2005:

	Medical Necessity Standard	Medical Necessity Expedited	Experimental/ Investigational Standard	Experimental/ Investigational Expedited	Total
2005	\$787,875	\$59,220	\$329,150	\$74,100	\$1,250,345

External Appeal Decisions by Health Plan in 2005

The following charts identify external appeal results by health plan for 2005. The charts categorize health plans based on whether the coverage is HMO, non-profit indemnity insurance, commercial insurance, Medicaid managed care, or Municipal Cooperative Health Benefit Plan coverage. When reviewing the charts, it is important to keep in mind that some health plans provide coverage to greater numbers of New Yorkers than others. Larger plans may have more external appeals than smaller plans because more people are covered under the plans.

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Aetna Health	24	13	3	8	66.7%
Affinity Health Plan*	1	0	0	1	0%
Atlantis Health Plan	7	5	0	2	71.4%
Capital District Physicians' Health Plan (CDPHP)	7	4	0	3	57.1%
CIGNA	15	7	0	8	46.7%
Empire HealthChoice	155	63	14	78	49.7%
Excellus (Rochester)	31	19	0	12	61.3%
Excellus (Utica Watertown)	4	2	0	2	50%
Excellus (Central NY)	14	9	0	5	64.3%
Excellus (Univera)	38	12	1	25	34.2%
Fidelis Care New York*	1	1	0	0	100%
GHI HMO Select	8	4	0	4	50%
Health Insurance Plan of Greater NY (HIP)	26	7	4	15	42.3%
Health Net of New York	90	43	4	43	52.2%
HealthNow New York, Inc.	45	10	1	34	24.4%
Independent Health Association (IHA)	9	4	0	5	44.4%
MDNY	10	4	0	6	40%
MVP Health Plan	11	4	0	7	36.4%
Oxford Health Plans	212	74	19	119	43.9%
Rochester Area HMO (Preferred Care)	5	1	0	4	20%
United Healthcare of New York	4	2	0	2	50%
Vytra Health Plans	9	3	0	6	33.3%
Totals	726	291	46	389	46.4%

* Child Health Plus only

Non-Profit Indemnity Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Excellus Health Plan, Inc. (Central NY)	69	30	5	34	50.7%
Excellus Health Plan, Inc. (Rochester)	14	8	1	5	64.3%
Excellus Health Plan, Inc. (Utica-Watertown)	19	5	2	12	36.8%
Group Health, Inc.	104	38	7	59	43.3%
HealthNow New York Inc.	42	13	1	28	33.3%
Vytra Health Services	1	1	0	0	100%
Totals	249	95	16	138	44.6%

Commercial Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Aetna Group	19	10	1	8	57.9%
CIGNA Health Group	2	1	0	1	50%
Empire HealthChoice Assurance	255	104	28	123	51.8%
GE Global Group	2	0	0	2	0%
Guardian Life Group	17	6	2	9	47.1%
Guardian Life Group (Dental)	7	4	0	3	57.1%
Horizon Healthcare Insurance Company of New York	34	14	6	14	58.8%
Metropolitan Group	15	5	3	7	53.3%
Mutual of Omaha Insurance	2	2	0	0	100%
New England Life Insurance	1	1	0	0	100%
Nippon Life Insurance Company	2	1	0	1	50%
Oxford Health Insurance	54	16	1	37	31.5%
PerfectHealth Insurance Co.	2	0	1	1	50%
UniCare Life & Health Insurance Company	2	1	0	1	50%
Union Labor Life Insurance Company	3	0	0	3	0%
United Healthcare Insurance Company of New York	69	23	1	45	34.8%
Totals	486	188	43	255	47.5%

Medicaid Managed Care Coverage	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Affinity Health Plan	2	0	0	2	0%
AmeriChoice	10	3	1	6	40%
Capital District Physicians' Health Plan (CDPHP)	1	0	0	1	0%
Community Choice	1	0	0	1	0%
Excellus (Rochester)	2	1	0	1	50%
Fidelis Care New York	7	3	0	4	42.9%
Healthfirst, Inc.	4	2	0	2	50%
Health Insurance Plan of Greater NY (HIP)	5	3	1	1	80%
HealthNow New York	6	0	0	6	0%
Health Plus	4	2	0	2	50%
Hudson Health Plan	1	1	0	0	100%
Rochester Area HMO (Preferred Care)	1	1	0	0	100%
Senior Health Partners	1	0	0	1	0%
Total Care, Inc.	1	1	0	0	100%
United Healthcare of New York	7	3	0	4	42.9%
WellCare	3	2	0	1	66.7%
Totals	56	22	2	32	42.9%

Municipal Cooperative Health Benefit Plans	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Orange-Ulster School Districts Health Plan	1	0	0	1	0%
Putnam/Northern Westchester Health Benefits Consortium	3	0	0	3	0%
State-Wide Schools Cooperative Health Plan	15	6	1	8	46.7%
St. Lawrence-Lewis Health Benefits Consortium	6	0	0	6	0%
Totals	25	6	1	18	28%

Totals For All Coverage Types	1542	602	108	832	46%
--------------------------------------	-------------	------------	------------	------------	------------

External Appeal Decisions by Health Plan for July 1, 1999 – December 31, 2005

The following charts identify the total external appeal results by health plan since the program's inception in 1999 through 2005.

Health Maintenance Organizations	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Aetna Health	215	87	20	108	49.8%
Affinity Health Plan*	1	0	0	1	0%
Atlantis Health Plan	39	23	2	14	64.1%
Capital District Physicians' Health Plan (CDPHP)	62	26	3	33	46.8%
CIGNA	93	40	11	42	54.8%
Empire HealthChoice	489	209	31	249	49.1%
Excellus (Rochester)	126	56	1	69	45.2%
Excellus (Utica Watertown)	29	13	2	14	51.2%
Excellus (Central NY)	64	28	6	30	53.1%
Excellus (Univera)	187	69	5	113	39.6%
Fidelis Care*	1	1	0	0	100%
GHI HMO Select	20	10	1	9	55%
Health Insurance Plan of Greater NY (HIP)	161	64	14	83	48.4%
Health Net of New York	358	154	26	178	50.3%
HealthNow New York, Inc.	288	77	16	195	32.3%
Health Plus*	3	1	0	2	33.3%
Independent Health Association (IHA)	29	10	1	18	37.9%
MDNY Healthcare, Inc.	34	17	3	14	58.8%
MVP Health Plan, Inc.	94	42	4	48	48.9%
Oxford Health Plans of New York, Inc.	1289	401	112	776	39.8%
Rochester Area HMO, Inc. (Preferred Care)	30	16	1	13	56.7%
United Healthcare of New York, Inc.	32	16	0	16	50%
Vytra Health Plans Long Island, Inc.	85	36	10	39	54.1%
Wellcare*	1	0	0	1	0%
Totals	3730	1396	269	2065	44.6%

* Child Health Plus only.

** Plans that are no longer in business have not been included.

Non-Profit Indemnity Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Excellus Health Plan (Central NY)	294	118	21	155	47.3%
Excellus Health Plan (Rochester)	55	24	2	29	47.3%
Excellus Health Plan (Utica-Watertown)	85	25	5	55	35.3%
Group Health, Inc.	493	152	75	266	46%
HealthNow New York Inc.	141	47	7	87	38.3%
Vytra Health Services	9	6	0	3	66.7%
Totals	1077	372	110	585	44.8%

Commercial Insurers	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Aetna Group	41	12	6	23	43.9%
Anthem Health & Life Insurance Company of New York	5	2	0	3	40%
CIGNA Health Group	74	36	3	35	52.7%
Continental Assurance Company	1	1	0	0	100%
Empire HealthChoice Assurance, Inc. *	1040	412	102	526	49.4%
Equitable Life Assurance Company of America	2	0	0	2	0%
First Reliance Standard Life Insurance Company	1	0	0	1	0%
GE Global Group	3	0	0	3	0%
Guardian Life Group	34	10	5	19	44.1%
Guardian Life Group (Dental)	11	5	1	5	54.5%
Health Net Insurance Company of New York	18	5	4	9	50%
Horizon Healthcare Insurance Company of New York	75	31	12	32	57.3%
Metropolitan Group	82	37	5	40	51.2%
Mutual of Omaha Group	7	6	0	1	85.7%
New England Life Insurance Company	2	2	0	0	100%
Nippon Life Insurance Company	5	2	0	3	40%

* Empire HealthChoice, Inc. converted to a for-profit commercial insurer in October 2002. This number includes the appeals conducted while the insurer was a non-profit insurer and a commercial insurer.

Oxford Health Insurance	121	41	5	75	38%
PerfectHealth Insurance Co.	2	0	1	1	50%
Phoenix Home Life	1	0	0	1	0%
Principal Life Insurance Company	1	0	0	1	0%
Trustmark Insurance Company	1	0	1	0	100%
UniCare Life & Health Insurance Company	23	6	6	11	52.2%
Union Labor Life Insurance Company	6	0	1	5	16.7%
United Healthcare Insurance Company of New York	352	150	13	189	46.3%
U.S. Life Insurance Company	1	0	0	1	0%
Totals	1909	758	165	986	48.3%

Medicaid Managed Care Coverage	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Affinity Health Plan	6	1	1	4	33.3%
AmeriChoice	14	6	1	7	50%
Buffalo Community Health Plan	1	0	0	1	0%
Capital District Physicians Health Plan (CDPHP)	3	0	0	3	0%
CenterCare Health Plan	2	0	1	1	50%
Community Choice	2	1	0	1	50%
Excellus (Rochester)	3	1	0	2	33.3%
Excellus (Central NY)	1	0	0	1	0%
GHI HMO Select	3	1	0	2	33.3%
Fidelis Care New York	24	7	0	17	29.2%
Healthfirst, Inc.	4	2	0	2	50%
Health Insurance Plan of Greater NY (HIP)	15	8	2	5	66.7%
HealthNow New York	11	0	2	9	18.2%
Health Plus	9	2	1	6	33.3%
Healthsource/HHP	2	1	0	1	50%
Hudson Health Plan	1	1	0	0	100%
Independent Health Association (IHA)	1	1	0	0	100%
Rochester Area HMO (Preferred Care)	1	1	0	0	100%
Senior Health Partners	1	0	0	1	0%
Total Care, Inc.	1	1	0	0	100%
United Healthcare of New York	10	5	0	5	50%
Vytra	3	0	0	3	0%
WellCare	10	4	1	5	50%
Totals	128	43	9	76	40.6%

Municipal Cooperative Health Benefit Plans	Total	Overtured	Overtured in Part	Upheld	Percentage Overtured or Overtured in Part
Catskill Area Schools Employees Benefit Plan	4	2	0	2	50%
Cayuga-Onondaga Area Schools Employees Health Plan	2	0	0	2	0%
Jefferson-Lewis School Employees Health Care Plan	4	0	1	3	25%
Orange-Ulster School Districts Health Plan	1	0	0	1	0%
Putnam/Northern Westchester Health Benefits Consortium	10	2	0	8	20%
State-Wide Schools Cooperative Health Plan	25	10	2	13	48%
St. Lawrence-Lewis Health Benefits Consortium	6	0	0	6	0%
Totals	52	14	3	35	32.7%
Totals For All Coverage Types	6896	2583	556	3757	45.5%

Disaster Planning and Preparation

The Department's ability to receive and assign external appeal requests is an essential and vital operation. After the widespread blackout that occurred in August of 2003, the Insurance Department further developed and refined its emergency protocols to be utilized in the event of an emergency or disaster situation, to ensure that the External Appeal Program will not be disrupted.

Access to Stored Information: Incoming external appeal applications and supporting documentation are scanned into a computer database. This database allows designated Insurance Department staff to view a consumer's application or supporting documentation at any time. On a daily basis, the Insurance Department's Systems Bureau backs up all stored information in the Albany external appeal database to a database in the Department's New York City office. In the event of an emergency situation at one location, the information will still be available through back-up at the second location. Designated Insurance Department staff members are also able to access the database off-site through laptops, which would still be operational in the event of an emergency situation such as a power outage.

Accepting External Appeal Applications: An emergency situation, such as a power failure or a systems failure, may impact the Department's ability to receive a faxed external appeal application under the normal procedure. The Insurance Department has therefore made arrangements to ensure that fax machines at alternate locations will be available. In addition, the external appeal application advises applicants to call the Department when an expedited appeal is submitted, so the Insurance Department can provide the applicant with any necessary instructions, including where to send the materials. The Insurance Department also has an arrangement with an answering service with live operators to answer any incoming telephone calls on weekends and holidays or when telephone service is unavailable in the Albany office. The answering service has a list of designated Department staff members to contact when calls are received, who are accessible by cellular telephone and pager.

Assigning Expedited Appeals: When an expedited external appeal is received in an emergency situation, a designated Insurance Department staff member will contact the randomly assigned external appeal agent by telephone to ensure that the agent is capable of receiving the external appeal application and assigning the appeal to a clinical peer for review. If the Insurance Department is unable to transmit the application to the agent by facsimile from the Albany office, the application will be faxed to the agent either by a designated New York City Insurance Department staff member or by using an off-site fax machine. If neither New York City or Albany Insurance Department staff are able to transmit external appeal requests to an agent via facsimile, the Insurance Department has an arrangement in place to have the application hand delivered to one of the certified external appeal agents.

In the event another emergency situation were to occur, the Insurance Department is confident that these emergency protocols will ensure that the External Appeal Program will remain operational and accessible.

Health Plan Surveys

In 2005, the Department surveyed health plans and asked whether they had any questions or suggested improvements for the New York External Appeal Program. Of the 41 health plans surveyed, 36 health plans did not have comments on the External Appeal Program. We received the following input from health plans and provided health plans with the following clarifications and explanations:

- Health plans suggested that an increased effort be made to make providers aware of the requirements of the external appeal law.
 - ✓ Under New York Insurance Law § 4904(c), a health plan must include a description of the right to an external appeal, including the timeframes to request an external appeal, in a final adverse determination notice.
- Health plans requested that for a provider's external appeal, when an external appeal agent upholds the plan's denial, the provider should bear the cost of the external appeal instead of the health plan.
 - ✓ Under New York Insurance Law § 4914(d), payment for an external appeal is the responsibility of the health plan. Any change to this requirement would have to be made legislatively.
- Health plans commented that the cost of the external appeal program is excessive for particular types of health care services.
 - ✓ Under Article 49 of the Insurance Law, the insured or the provider may have the right to appeal a medical necessity, experimental/investigational, or clinical trial denial, irrespective of the cost of such appeal compared to the cost of the disputed health care service.

The Department also requested that health plans list any requests for new or unique types of health care services or treatments received in the past year. Many of the health plans may consider these new or unique types of health care services or treatments as experimental or investigational, and thus these procedures may be the subject of an external appeal request. Some of the new or unique health care services or treatments are as follows:

- Artificial spinal discs;
- Hip resurfacing;
- Robotic surgical procedures;
- Prescription drugs such as Tarceva, Retisert, Xifaxan, and Zometa;
- Botox treatments for excessive sweating;
- Hyperbaric chamber treatment for head and mouth cancer;
- Dual cord stem cell transplant;
- Virtual colonoscopy;
- Cardiac calcium scoring;
- Promethius liver fibrosis test;
- Biofeedback for the treatment of headaches;
- Oncotype DX assay for breast cancer;
- Influenza rapid diagnostic testing;
- Oxynium knee implants;
- RF and laser ablation of varicose veins.

State External Appeal Survey Results

A complete survey of the External Appeal Programs of all states was included in our 2002 External Appeal Annual Report. For this report, the Insurance Department followed-up with the states that have a high volume of external appeals. While the number of appeals conducted in New York has increased dramatically from 2002 to 2005, most other states have also seen an increase in external appeals. This increase in volume reveals that External Appeal Programs continue to be an important consumer protection not only in New York, but in other states across the country.

The following chart contains general information regarding the states' external appeal programs. It also compares the volume of external appeal reported in 2002 with the 2005 volume of external appeals.

	Total External Appeal Decisions in 2002*	Total External Appeal Decisions in 2005	Number of External Appeal Agents	Expedited Review Timeframe (if available)	Level of Internal Appeal that Must be Exhausted to Appeal Externally	Who May File an External Appeal?
California	702	1079	1	E/I: 7 days after agent receives information. Medical Necessity: 3 days after agent receives information.	1st level of internal appeal, but the member can request a waiver of the internal appeal process.	Patient or patient's agent. Provider may assist patient with process if authorized by patient.
Maryland	Not Available	237	3	24 hours from the agent's receipt of the appeal.	1st level of internal appeal, unless emergency or compelling reason exists.	Patient or provider with patient's authorization.
New York	878	1542	3	3 days from the agent's receipt of the appeal.	1st level of internal appeal, but the member can request a waiver of the internal appeal process.	Patient, patient's designee, or if the utilization review was conducted retrospectively, the provider.

New Jersey	186	342	2	48 hours from the agent's receipt of the appeal.	2nd level internal appeal.	Patient or provider if the provider obtains the patient's consent after the denial is made.
Pennsylvania	203	370	9	2 business days from the agent's receipt of the appeal.	2nd level internal appeal.	Patient, patient's designee or provider. The provider pays the cost of the appeal if the health plan's decision is upheld.
Texas	719	235	17	5 days after the agent receives information or 8 days after the agent's receipt of the appeal.	1st level appeal, but if the member has a life-threatening condition, the internal appeal process may be bypassed.	Patient, patient's designee or provider.

* The 2002 external appeal data was reported to the Insurance Department in response to a survey and appeared in the 2002 New York External Appeal Annual Report. All other data was gathered during a survey conducted by the Insurance Department in the spring and summer of 2006.

Types of Denials Subject to External Appeal

States have taken similar approaches to external appeal eligibility for the different types of denials that are issued by health plans. All the states surveyed subject medical necessity denials to external appeal. Most states also subject experimental or investigational denials, clinical trial denials and cosmetic denials to external appeal. Some states subject out-of-network referral denials to external appeal, but on a case-by-case basis.

	Medical Necessity Denials	Experimental or Investigational Denials	Clinical Trial Denials	Out of Network Referral Denials	Cosmetic Denials
California	Yes	Yes	Yes, included under experimental or investigational.	Case-by-case depending on coverage under contract and availability of in-network provider.	Yes, if relates to reconstructive surgery.
Maryland	Yes	Yes	Yes, included under experimental or investigational.	Yes, if health plan does not satisfy burden to show an adequate network.	No, but if relates to functional problem, determined on case-by-case basis.
New York	Yes	Yes	Yes	No	Yes
New Jersey	Yes	Yes	Yes	Only if a provider is not available in-network.	Yes, if interfering with function.
Pennsylvania	Yes	Included in medical necessity.	No, specifically excluded.	Case by case basis.	Yes, if a functional impairment is shown.
Texas	Yes	No	No	No	Yes, if denial is on basis that medical necessity was not met.

Closing Remarks

Since the External Appeal Program's inception six years ago, it continues to provide consumers with an effective means to gain access to an independent appeal process to review medical necessity, experimental, investigational, or clinical trial denials. Only through the mutual cooperation of the Health Department, the Insurance Department, providers, health plans and consumer groups has the External Appeal Program succeeded. The New York External Appeal Program continues to be used as a model for other states' programs and has experienced the highest volume of appeals. The Insurance Department is committed to the External Appeal Program and will continue to work with consumers, providers and health plans to maintain standards of excellence and to ensure that consumers are able to access the critical protections that this program provides.