

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION

Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application

- Number 11 is only required if the patient has designated someone other than the provider to act on their behalf.
- Number 12 indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
- The Type of Review must be completed in number 13 if an expedited appeal is being requested. External Appeals can only be expedited if the denial falls into one of these categories. If you already received the services your appeal cannot be expedited. You must also indicate if this is for a Standard Formulary Exception or a Standard External Appeal.
- Number 14 is required if the provider is submitting the application on their own behalf or behalf of the patient.
- Number 15 is to be used to describe the services requested. You can attach a separate document with this information.
- Number 17 relates to the fee that a health plan may charge for the external appeal. The final adverse determination will indicate if the health plan charges a fee.
- Patient Consent to the Release of Records for NYS External Appeal – this document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician's Attestation

- For medical necessity, experimental/investigational, and out-of-network appeals, the first section is required if the attending physician is requesting an expedited appeal because the standard 30-day timeframe would jeopardize the patient's life, health or ability to regain maximum function, or the delay would pose an imminent or serious threat to the patient's health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
- For formulary exception appeals, the first section is required if the attending physician or prescriber is requesting an expedited appeal because the patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug. The attending physician or prescriber must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination with 24 hours of receipt. The decision must be issued even in the event of

incomplete medical information or unanswered questions due to the inability to reach the attending physician/prescriber.

- Number 10 is required for Experimental/Investigational and Out-of-Network Service denials (where the health plan offers an alternate in-network service that is not materially different from the out-of-network service). Subsections a, c and d are required when appealing an experimental/investigational denial.
 - Subsections b, c and d are required for Out-of-Network Service denials.
 - Subsection c. must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient's condition. Two articles are required. This section MUST be completed in full, "See attached" will not suffice. The documents that are acceptable for submission are described in subsection d. There is no requirement that the two documents be from different categories.
- Number 11 is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- Number 12 is required for the Experimental/Investigational denials for treatment of a rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient's attending physician. They must disclose any relationship with the patient's attending physician and indicate which definition of "rare disease" applies to the patient's condition.
- Number 13 must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider's curriculum vitae, Board certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- Number 14 must be signed by a Physician. Physician is defined in NYS Education law as an MD or DO. Attestations signed by any other provider will not be accepted. For formulary exception appeals, #14 may be signed by a physician or prescriber.