§ 4914. Procedures for external appeals of adverse determinations. (a) The superintendent shall establish procedures by regulation to randomly assign an external appeal agent to conduct an external appeal, provided that the superintendent may establish a maximum fee which may be charged for any such external appeal, or the superintendent may exclude from such random assignment any external appeal agent which charges a fee which he deems to be unreasonable.

(b) (1) The insured shall have four months to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the insured have jointly agreed to waive any internal appeal, or after the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19. Where applicable, the insured's health care provider shall have sixty days to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

(2) The external appeal agent shall make a determination with regard to the appeal within thirty days of the receipt of the request therefor, submitted in accordance with the superintendent's instructions. The external appeal agent shall have the opportunity to request additional information from the insured, the insured's health care provider and the insured's health care plan within such thirty-day period, in which case

the agent shall have up to five additional business days if necessary to make such determination. The external appeal agent shall notify the insured, the insured's health care provider where appropriate, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

(3) Notwithstanding the provisions of paragraphs one and two of this subsection, if the insured's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the insured, or if the insured is entitled to an expedited external appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19, the external appeal shall be completed within no more than seventy-two hours of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the insured, the insured's health care provider where appropriate, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

(4) (A) For external appeals requested pursuant to paragraph one of subsection (b) of section four thousand nine hundred ten of this title, 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 health care plan acted reasonably and with sound medical judgment and in the best interest of the patient. When the external appeal agent makes its determination, it shall consider the clinical standards of the plan, the information provided concerning the patient, the attending physician's recommendation, applicable and generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations. Provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers,

(ii) be accompanied by a notice of appeal determination which shall include the reasons for the determination; provided, however, that where the final adverse determination is upheld on appeal, the notice shall include the clinical rationale, if any, for such determination,

(iii) be subject to the terms and conditions generally applicable to

benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the insured, and

(v) be admissible in any court proceeding.

(B) For external appeals requested pursuant to paragraph two of subsection (b) of section four thousand nine hundred ten of this title, the external appeal agent shall review the proposed health service or procedure for which coverage has been denied and, in accordance with the provisions of this title and the external agent's investigational treatment review plan, make a determination as to whether the patient costs of such health service or procedure shall be covered by the health care plan; provided that such determination shall:

(i) be conducted by a panel of three or a greater odd number of clinical peer reviewers,

(ii) be accompanied by a written statement:

(a) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, based upon review of the applicable medical and scientific evidence and, in connection with rare diseases, the physician's certification required by subsection (g-7) of section four thousand nine hundred of this article and such other evidence as the insured, the insured's designee or the insured's attending physician may present (or upon confirmation that the recommended treatment is a clinical trial), the insured's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the insured's condition or disease or, for rare diseases, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure (or, in the case of a clinical trial, is likely to benefit the insured in the treatment of the insured's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

(b) upholding the health plan's denial of coverage;

(iii) be subject to the terms and conditions generally applicable to

benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the insured, and

(v) be admissable in any court proceeding.

As used in this subparagraph (B) with respect to a clinical trial, patient costs shall include all costs of health services required to provide treatment to the insured according to the design of the trial. Such costs shall not include the costs of any investigational drugs or devices themselves, the cost of any nonhealth services that might be required for the insured to receive the treatment, the costs of managing the research, or costs which would not be covered under the policy for noninvestigational treatments.

(C) For external appeals requested pursuant to paragraph three of subsection b of section four thousand nine hundred ten of this title 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.

(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 alternate recommended in-network health service.

(ii) If a determination is made that the out-of-network health service is not materially different from the alternate recommended in-network health service, the out-of-network health service shall not be covered by the health plan.

(iii) If a determination is made that the out-of-network health service is materially different from the alternate recommended in-network health service, 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:

(I) be accompanied by a written statement:

(1) that the out-of-network health service shall be covered by the health care plan either: when a majority of the panel of reviewers

determines, upon review of the treatment requested by the insured, the alternate recommended health service proposed by the plan, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the applicable medical and scientific evidence, the insured's medical record, and any other pertinent information that the out-of-network health service is likely to be more clinically beneficial than the alternate recommended 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

(2) uphold the health plan's denial of coverage;

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

(III) be binding on the plan and the insured; and

(IV) be admissible in any court proceeding.

(D) For external appeals requested pursuant to paragraph four of subsection (b) of section four thousand nine hundred ten of this title relating to an out-of-network referral 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 referral shall be covered by the health plan; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

(I) that the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the training and experience of the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the insured's medical record, and any other pertinent information, that the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and that the out-of-network provider has the appropriate training and experience to meet the particular health

care needs of an insured, is able to provide the requested health service, and is likely to produce a more clinically beneficial outcome; or

(II) upholding the health plan's denial of coverage;

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

(iv) be binding on the plan and the insured; and

(v) be admissible in any court proceeding.

(c) No external appeal agent or clinical peer reviewer conducting an external appeal shall be liable in damages to any person for any opinions rendered by such external appeal agent or clinical peer reviewer upon completion of an external appeal conducted pursuant to this section, unless such opinion was rendered in bad faith or involved gross negligence.

(d) (1) Except as provided in paragraphs two and three of this subsection, payment for an external appeal shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days, from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

(2) If an insured's health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the health care plan's determination in whole, payment for the external appeal shall be made by the health care provider in the manner and subject to the timeframes and requirements set forth in paragraph one of this subsection.

(3) If an insured's health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the health care plan's determination in part, payment for the external appeal shall be evenly divided between the health care plan and the insured's health care provider who requested the external appeal and

shall be made by the health care plan and the insured's health care provider in the manner and subject to the timeframes and requirements set forth in paragraph one of this subsection; provided, however, that the superintendent may, upon a determination that health care plans or health care providers are experiencing a substantial hardship as a result of payment for the external appeal when the external appeal agent upholds the health care plan's determination in part, in consultation with the commissioner of health, promulgate regulations to limit such hardship.

(4) If an insured's health care provider was acting as the insured's designee, payment for the external appeal shall be made by the health care plan. The external appeal and any designation shall be submitted on a standard form developed by the superintendent in consultation with the commissioner of health pursuant to subsection (e) of this section. The superintendent shall have the authority upon receipt of an external appeal to confirm the designation or request other information as necessary, in which case the superintendent shall make at least two written requests to the insured to confirm the designation. The insured shall have two weeks to respond to each such request. If the insured fails to respond to the superintendent within the specified timeframe, the superintendent shall make two written requests to the health care provider to file an external appeal on his or her own behalf. The health care provider shall have two weeks to respond to each such request. If the health care provider does not respond to the superintendent's requests within the specified timeframe, the superintendent shall reject the appeal. If the health care provider responds to the superintendent's requests, payment for the external appeal shall be made in accordance with paragraphs two and three of this subsection.

(e) The superintendent, in consultation with the commissioner of health, shall promulgate by regulation a standard description of the external appeal process established under this section, which shall provide a standard form and instructions for the initiation of an external appeal by an insured.