§ 4904. Appeal of adverse determinations by utilization review agents. 1. An enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider, may appeal an adverse determination rendered by a utilization review agent.

1-a. An enrollee or the enrollee's designee may appeal an out-of-network denial by a health care plan by submitting: (a) a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and (b) two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the enrollee than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

1-b. An enrollee or the enrollee's designee may appeal a denial of an out-of-network referral by a health care plan by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, provided that: (a) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service; and (b) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:

(a) continued or extended health care services, procedures or

treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section forty-nine hundred three of this title; or

(b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination; or

* (c) potential court-ordered mental health and/or substance use disorder services pursuant to paragraph (b) of subdivision two of section forty-nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. Provided that the enrollee or the enrollee's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance use disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

* NB Effective until January 1, 2027

* (c) potential court-ordered mental health and/or substance-related and addictive disorder services pursuant to paragraph (b) of subdivision two of section forty-nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance-related and addictive disorder treatment provided pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. Provided that the enrollee or the enrollee's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance-related and addictive disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance-related and addictive disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

* NB Effective January 1, 2027

3. A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The

utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within thirty days of the receipt of necessary information to conduct the appeal and, upon overturning the adverse determination, shall comply with subsection (a) of section three thousand two hundred twenty-four-a of the insurance law as applicable. The utilization review agent shall notify the enrollee, the enrollee's designee and, where appropriate, the enrollee's health care provider, in writing, of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include:

(a) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and

(b) a notice of the enrollee's right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of financial services as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals. A utilization review agent shall have procedures for obtaining an enrollee's, or enrollee's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the commissioner. Written and telephone notification to an enrollee or the enrollee's designee under this section may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of a preference to receive such notifications by electronic means. An organization shall permit the enrollee and the enrollee's designee to change the preference at any time. To the extent practicable, written and telephone notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The utilization review agent shall retain documentation of preferred notification methods and present such records to the commissioner upon request.

4. Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed

by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

5. Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.