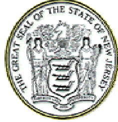


New Jersey Department of Banking and Insurance

APPLICATION FOR THE INDEPENDENT HEALTH CARE APPEALS PROGRAM

AN EXPLANATION OF THE INDEPENDENT HEALTH CARE APPEALS PROGRAM (IHCAP)

A covered person, and any provider acting on behalf of the covered person with the covered person's consent, who continues to disagree with a carrier's decision about the medical appropriateness of requested covered services after appealing that decision through the carrier's internal appeal process has the right to appeal the decision to the Independent Health Care Appeals Program (IHCAP) operated by the New Jersey Department of Banking and Insurance (DOBI). Through the IHCAP, the appeal will be reviewed by an Independent Utilization Review Organization (IURO).

A covered person, or a provider acting on behalf of a covered person with the covered person's consent, MUST comply with the carrier's internal appeal process BEFORE an appeal will be considered at the IHCAP, unless the carrier either fails to meet the required deadlines for completing Stage 1 or Stage 2 of the carrier's internal appeal process, or waives its right to perform an internal review. The carrier must make a decision about the appeal in accordance with the medical urgency of the case; however, for standard reviews, the carrier should not take more than 5 business days to make a decision at Stage 1, or more than 20 business days for Stage 2 reviews. For urgent or emergency reviews, carriers must issue a decision within 72 hours.

An appeal to the IHCAP **must be made within 60 days** following the date of receipt of a Stage 2 decision from the carrier. An IURO designated by DOBI will determine whether the covered person was deprived of a medically necessary covered service as a result of the carrier's utilization management decision. DOBI will assign appeal requests to approved IUROs.

Preliminary Review

Upon receipt of the request to review an appeal from DOBI, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

1. the individual was a covered person of the carrier at the time of the action on which the appeal is based;

2. the service that is the subject of the appeal reasonably appears to be a covered service under the terms of the contract between the covered person and the carrier;

3. the covered person, or provider acting on behalf of the covered person with the covered person's consent, has completed the carrier's internal appeals process; and

4. the covered person, or provider acting on behalf of the covered person with the covered person's consent, has provided all information required by the IURO and DOBI to make the preliminary determination. This information includes the appeal form, a copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the carrier and any other relevant health care provider.

The IURO will complete the preliminary review and notify the covered person and/or provider in writing as to whether the appeal has been accepted for processing and if not, the reason(s) why within 5 business days of receipt of the request.

Full Review of Appeal

Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the carrier's utilization management determination, the covered person was deprived of medically necessary covered services. In reaching this determination, the IURO will take into consideration all information submitted by the parties and information deemed appropriate in the opinion of the IURO including: pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the carrier.

1. The IURO shall complete its review and issue its decision as soon as possible in accordance with the medical urgency of the case, but no later than 30 business days following receipt of all documentation necessary to complete the review, unless the IURO has to extend its review period for a reasonable time due to circumstances beyond the IURO's control. If the IURO needs an extension, the IURO must provide written notice prior to the end of the original 30 business day review period to DOBI, the covered person and/or the provider and carrier setting forth the status of the review and the specific reasons for the delay.

2. The IURO will notify DOBI when a carrier fails to comply with requests for information and any other aspect of the external review process.

3. The IURO's written appeal decision will be sent to the covered person and/or the provider, the carrier and DOBI, with a cover letter of transmittal signed by a responsible representative of the IURO. The written decision of the IURO will be signed by the IURO's medical director and will indicate every basis for the IURO's decision.

4. If the IURO determines that the covered person was deprived of medically necessary covered services, the IURO's written decision will specify the appropriate covered health care services the covered person should receive.

5. The carrier must comply with the decision of the IURO.

6. The IURO shall conduct emergent and urgent reviews, and will disclose the method and basis for rendering such decisions.

BEFORE YOU MAIL YOUR APPEAL

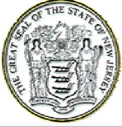
- Attach the filing fee of $25.00. Make the check or money order payable to "New Jersey Department of Banking and Insurance." DO NOT SEND CASH! (NOTE: The filing fee is reduced to $2.00 if there is financial hardship evidenced by participation in the Pharmaceutical Assistance to the Aged or Disabled program, Medicaid, NJFamilyCare, General Assistance, SSI or New Jersey Unemployment Assistance.)
- Attach a copy of the final written decision from the carrier.
- Attach a copy of the Summary of Insurance Coverage from the covered person's certificate, handbook, policy or contract, if available.
- Sign the form.
- For providers filing on behalf of a covered person, attach a copy of the signed and dated *Consent to Representation in Appeal of a Utilization Management Determination and Authorization of Release of Medical Records for Appeal and Arbitration of Claims* form.
- Attach a copy of the *Notice of Intent to Appeal an Adverse UM Determination – Stage 3* sent to the patient
- Attach a copy of all medical records and correspondence to be reviewed by the IURO.

MAIL TO: New Jersey Department of Banking and Insurance, Office of Managed Care, P.O. Box 329, Trenton, NJ 08625-0329 (courier service: 20 West State Street, 9th floor)

IMPORTANT: Send copies of any requested documents. Do not send original documents; they will not be returned.

IF YOU HAVE QUESTIONS, PLEASE CALL 1-609-292-5316 ext. 50998
OR, OUR TOLL FREE NUMBER: 1-888-393-1062

DETACH AND RETAIN THIS PAGE; IT CONTAINS IMPORTANT INFORMATION REGARDING THE IURO APPEAL PROCESS. RETAIN A PHOTOCOPY OF THE "REQUEST FOR REVIEW BY THE INDEPENDENT HEALTH CARE APPEALS PROGRAM" FORM FOR YOUR RECORDS.



New Jersey Department of Banking and Insurance

APPLICATION FOR THE INDEPENDENT HEALTH CARE APPEALS PROGRAM

New Jersey Department of Banking and Insurance
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329
Courier: 20 West State Street

For NJDOBI Use ONLY
Date Rec'd:________________
File No.: _________________
Category: _________________
IURO: ____________________

Instructions: Read and complete the entire form (please print or type). The form must be signed and dated. Forward the completed form, including the fee and any attachments, to the address above.

COVERED PERSON/SUBSCRIBER INFORMATION

Name of Covered Person		Covered Person's ID Number
Name of Subscriber		Subscriber ID Number
Street Address of Covered Person	City	State / Zip Code
Home Telephone Number ( )	Business Telephone Number ( )	Medical Record:
Name of Carrier		

Coverage Through: ☐ Employer (State) ☐ Employer (Federal) ☐ Employer (Private) ☐ Individual/Nongroup ☐ Medicare ☐ Medicaid ☐ NJFamilyCare

Attach a copy of the Summary of Insurance Coverage or Schedule of Benefits/Covered Services.

INDIVIDUAL FILING THE APPEAL

Name of Person Filing the Appeal	Filing Type: ☐ Consumer ☐ Provider* **Providers MUST have the consent of the covered person.*

PROVIDER INFORMATION

Name of Health Care Provider		
Street Address	City	State / Zip Code
Name of Contact Person for Provider		Telephone Number ( )

FILING FEE

Please indicate the fee enclosed (there is a $25.00 filing fee except in cases of financial hardship):
☐ $25.00 ☐ $2.00 (submit evidence of financial hardship)

INTERNAL CARRIER APPEAL PROCESS

1. Have you utilized the Carrier's internal appeal process? ☐ Yes ☐ No
   a. Have you received a final written decision from the Carrier? ☐ Yes** ☐ No
2. If you checked "Medicare," have you filed an appeal with Medicare? ☐ Yes ☐ No

***Attach a copy of the final written decision*

Name of Covered Person:	Covered Person's ID Number:
SUMMARY OF APPEAL	
Summarize the Appeal Issues *(attach additional pages if necessary)*:	
AUTHORIZATION BY THE COVERED PERSON FOR RELEASE OF INFORMATION	

I understand that a copy of this form and any enclosures may be sent to the Independent Utilization Review Organization (IURO) and the Carrier named in the appeal and I authorize the release of any medical and/or administrative records pertinent to this appeal to the IURO selected by the New Jersey Department of Banking and Insurance.

Signature of covered person	Date

I am filing as a health care provider acting on behalf of a covered person with the covered person's consent. I have attached a copy of the relevant Consent to Representation in Appeal of a Utilization Management Determination and Authorization of Release of Medical Records for Appeal and Arbitration of Claims*. To my knowledge and belief, I am authorized to file this application for appeal and to release pertinent medical and/or administrative records to the IURO.*

Signature	Date