TENTH LEGISLATIVE REPORT
INDEPENDENT HEALTH CARE APPEALS PROGRAM
DEPARTMENT OF HEALTH AND SENIOR SERVICES

This is the tenth report to the Legislature on the managed care coverage denial appeal process. This report covers the period from January 16, 2003 through July 15, 2003.

The Health Care Quality Act, enacted on August 7, 1997, and amended on January 16, 2001, gives New Jersey residents many important consumer rights. Among the most significant is the right to appeal to an independent organization for a binding determination when a carrier denies, limits or terminates a covered service on the grounds that it is not medically necessary. The right of appeal is offered through the Independent Health Care Appeals Program (IHCAP) and is administered by the New Jersey Department of Health and Senior Services (Department).

Two hundred and seventy eight (278) requests for an external appeal were filed with the Department's Office of Managed Care during the time period of this report. Of the 278 requests filed, 189 met the requirements for processing and were forwarded to an independent utilization review organization (IURO) for preliminary review, where 174 were accepted by the IUROs for full review. Reasons for rejection and subsequent return of the appeal to the appellant included, in order of prevalence: non-eligibility of the member due to federal law preemption under ERISA; not a utilization management (UM) issue; out of state coverage; provider did not have the member's consent to file the appeal on his/her behalf; request not received within 60 days of Stage 2 denial; or the failure to exhaust the carrier's internal appeal process.

Of the 174 appeals accepted by the IUROs for full review, 113 appeals have been completed and 61 are pending. Of the 113 appeals completed, the independent panel supported the carrier's decision 65 times (58 %) and disagreed with the carrier's decision 48 times (42 %). In the previous 6 month period, July 16, 2002 through January 15, 2003, the review panel agreed with the carrier in 48% of cases. However, it should be noted that the overall numbers remain small, and that caution should be used in observing changes from one reporting period to the next. The most frequent categories of appeals in descending order of occurrence are: denial of inpatient hospital days; denial of level of care for hospital inpatients; denial based on cosmetic procedure versus medical necessity; denial of behavioral health services (in-patient and out-patient); denial of surgical procedures; and denial based on the carrier's determination that a requested service was experimental/investigational. The first two categories involving hospital inpatients accounted for substantially more than all the other categories combined.

Two tables are attached demonstrating the number of appeals filed for each carrier. The first table indicates the number of appeals and outcomes from March 1997, when the HMO regulations went into effect, through July 15, 2003.

The second table represents the number of appeals and outcomes during the period of this report, January16, 2003 through July 15, 2003. The first column indicates the market share for each carrier's HMO business only. The market share for non-HMO business is not recorded by the Department of Banking and Insurance, and thus not shown. The second column provides the total number of appeals accepted for full review by the independent panel. Appeals categorized as completed are those for which the panel has communicated its determination to the carrier. Appeals that are still in the process of being reviewed by the panel are considered pending. The third column shows the independent panel's determination. If the panel determines that the carrier's determination of medical necessity was appropriate, the panel upholds the carrier's decision. However, if the panel determines that the consumer is being denied medically appropriate care, the panel disagrees with the carrier's decision and decides in favor of the consumer. If all or part of the panel's decision is in favor of the consumer, the carrier shall promptly provide coverage for the health care services found by the panel to be medically necessary covered services.

This report indicates a 43% increase in the number of appeals filed by consumers over the previous 6 month period (278 compared to 194). The number of requests that ultimately went forward to a full review also increased (174 compared to 131). The total number of appeals filed, however, continues to remain small considering the large number of residents (over 3.3 million) enrolled in HMOs and other managed care plans in New Jersey, as reflected in the calendar year table below:

	External Appeal Requests Filed with DHSS that Met Processing Requirements	**External Appeals Accepted By IUROs for Full Reviews**
CY 1997	27	25
CY 1998	122	104
CY 1999	174	144
CY 2000	174	133
CY 2001	303	273
CY 2002	260	233
CY 2003 as of 7/15/03	199	183

How the Appeal System Works

It is important to remember that consumers are required to exhaust their carrier's internal appeal process before submitting an appeal for consideration by an independent panel. Under New Jersey law, all carriers must have an internal appeal process that meets standards set by the Department. This requirement was established to provide an incentive for carriers to resolve most disputes internally, with only unresolved issues rising to the level of the external appeal process.

During the period covered by this report, all external appeal case reviews were conducted by panels convened by the Peer Review Organization of New Jersey (PRONJ) or the Island Peer Review Organization (IPRO). These panels, consisting of medical professionals, including specialty physicians appropriate to the area under review, examine cases on the basis of medical records and other documents, generally accepted practice guidelines and applicable clinical protocols. The cost of the review is paid by the carrier and was approximately $600 for this reporting period. Consumers pay a $25 filing fee for an external appeal, which can be reduced to $2 in cases of financial hardship. During the period of this report, there were only 7 cases of financial hardship.

Consumers are given up to 60 days from the date of a carrier's final denial of an internal appeal of a coverage request to file an external appeal. Under routine circumstances, a decision must be rendered by the external appeals panel within 30 business days after receiving all documents necessary to complete the review, but the panel can act within a matter of hours, if necessary.

Consumer Education

By New Jersey law, consumers who are denied coverage based on lack of medical necessity for an otherwise covered medical procedure or service must be given an appeal form that includes instructions on how to file an appeal. On the few occasions when the Department has learned that a carrier has failed to notify its member of the right to appeal, the Department has taken prompt corrective action.

The Department also informs consumers about their rights, including the right to appeal, by publishing the annual HMO report card. Our seventh report card will be made available to the public in the fall of 2003. Consumers can access it through the Department's web site at www.state.nj.us/health, through their workplace or in mailings from the Department.

In addition to the appeals system, the Department operates a hotline (1-888-393-1062) for consumers to register complaints about their carriers. During the period of this report, January 16, 2003 through July 15, 2003, the Department handled 2013 telephone inquiries and complaints and 518 written complaints. These complaints involve issues such as access to care, quality of care, and denial of coverage issues.

Table 1

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
March 15, 1997 - January 15, 2003

Carrier	HMO Market Share*	Total Appeals		Panel Determination	
		Pending	Completed	Disagree With Plan	Agree With Plan
Aetna Health	24.5%	16	205	95	110
AmeriChoice	8.3%	1	7	4	3
Amerigroup	4.7%	0	22	13	9
AmeriHealth	7.3%	4	80	38	42
AtlantiCare**		0	1	0	1
Cigna	4.2%	2	91	52	39
First Option**		0	28	9	19
Health Net	15.9%	11	140	67	73
HIP**		0	4	3	1
Horizon	22.0%	18	269	135	134
NYLCare**		0	27	12	15
One Health Plan	0.1%	0	1	0	1
Oxford	6.8%	9	118	47	71
Prudential**		0	40	16	24
The Guardian***		0	5	3	2
United	3.1%	2	14	4	10
University	2.5%	0	4	3	1
WellChoice	0.6%	0	1	1	0
Total		**63**	**1057**	**502**	**555**

*Source: Department of Banking and Insurance (3rd Quarter 2002)
**Inactive HMOs
***Carrier is not an HMO

Table 2

New Jersey Department of Health and Senior Services
Independent Health Care Appeals Program
January 16, 2002 - January 15, 2003

Carrier	HMO Market Share*	Total Appeals		Panel Determination	
		Pending	Completed	Disagree With Plan	Agree With Plan
Aetna Health	24.5%	16	16	7	9
AmeriChoice	8.3%	1	4	1	3
Amerigroup	4.7%	0	4	1	3
AmeriHealth	7.3%	4	10	3	7
Cigna	4.2%	2	7	4	3
Health Net	15.9%	10	19	10	9
Horizon	22.0%	17	41	18	23
One Health Plan	0.1%	0	1	0	1
Oxford	6.8%	9	7	1	6
The Guardian		0	1	0	1
United	3.1%	2	1	1	0
University	2.5%	0	1	1	0
WellChoice	0.6%	0	1	1	0
Total		**61**	**113**	**48**	**65**

*Source: Department of Banking and Insurance (1st Quarter 2003)