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SEMI-ANNUAL LEGISLATIVE REPORT
INDEPENDENT HEALTH CARE APPEALS PROGRAM
DEPARTMENT OF BANKING AND INSURANCE

This is the semi-annual report to the Legislature on activities related to the Independent Health Care Appeals Program from July 16, 2015 through January 15, 2016.

The Health Care Quality Act established the Independent Health Care Appeals Program to provide covered persons with the right to appeal to an independent utilization review organization (IURO) a carrier's denial, limitation or termination of a covered service on the grounds that it is not medically necessary. The overturn of a carrier's denial signifies that the IURO determined, after reviewing all medical information submitted by the carrier and the covered person, that the services requested for the covered person were medically necessary and appropriate, and should therefore be covered by the carrier. If all or part of the IURO's decision is in favor of the covered person, the carrier is required to promptly provide coverage for the healthcare services found by the IURO to be medically necessary covered services. The IURO's decision is binding on the carrier and the covered person, except if other remedies are available under state or federal law. The New Jersey Department of Banking and Insurance administers the Independent Health Care Appeals Program and currently contracts with two IUROs to conduct the appeal reviews.

Five hundred sixty five (565) external appeals were filed with the Department's Office of Managed Care during the time period of this report. Of the 565 appeals, 315 were accepted for review by the IUROs. Appeals determined to be ineligible for the Independent Health Care Appeals Program were rejected for the following reasons: failure to exhaust the carrier's internal appeal process; not a utilization management (UM) issue; member is covered by self-funded plan; fair hearing request; failure to provide signed consent to appeal; issue already resolved; out of state coverage; appeal untimely; and the appeal involves a non-covered benefit.

The IUROs rendered decisions on 315 appeals during this period. Of the 315 appeals, the IURO upheld the carrier's denial 169 times (53.7%) and overturned or modified the carrier's denial 146 times (46.3%). In the previous 6-month period, January 16, 2015 through July 15, 2015, the IURO rendered decisions on 266 appeals. The carrier's denial was upheld in 52.3% of the cases and overturned or modified in 47.7% of the cases. However, it should be noted that the overall numbers remain small, and caution should be used in observing changes from one reporting period to the next.

The appeals involved various types of medical service denials as shown in descending order of occurrence in the table below:

Independent Health Care Appeals Program
July 16, 2015 – January 15, 2016

Category	Total
Inpatient admission	63
Covered medication	37
Home health care	32
Reduction of acuity level (inpatient)	31
Outpatient medical treatment/diagnostic testing	29
Inpatient hospital days	27
Outpatient rehabilitation therapy (PT, OT, Speech, Cardiac, etc.)	20
Inpatient behavioral health treatment	19
In-network exception	11
Dental – coverage under Medicaid contract	10
Surgical procedure	8
Medical equipment (DME) and or supplies	8
Skilled nursing facility	7
Service considered experimental/investigational	6
Outpatient behavioral treatment	4
Emergency room treatment	2
Service considered cosmetic, not medically necessary	1
	315

The appeals involved various medical specialties as shown in descending order of occurrence in the table below:

Medical Specialty	Total Cases
Pediatrics	36
Internal Medicine	33
Psychiatry	31
Rehabilitation	23
Gastroenterology	23
Infectious Disease	19
General Surgery	15
Cardiology	13
Neurology	10
Pediatric Endocrinology	10
Oral/Maxillofacial	8
Orthopedics	7
Hematology Oncology	7
OB/GYN	6
Radiation Oncology	6
Pain Management	5
Dental	5
Pulmonary	5
Pediatric Pulmonary	5
Nephrology	5
Plastic Surgery	5
Family Medicine	5
Endocrinology	4
Oncology	4
Dermatology	3
Geriatrics	3
ENT	3
Urology	3
Rheumatology	2
Anesthesiology	2
Chiropractic	2
Ophthalmology	2
Neurosurgery	2
Other	3
Vascular Surgery	1
Otolaryngology	1

The number and disposition of appeals filed for each carrier is shown on the table below. The table does not include four carriers that had only one appeal each during the six month period.

			IURO Determination			
Carrier	**Market Share***	**Total Appeals Completed**	**Disagree With Plan**	**% Disagree With Plan**	**Agree With Plan**	**% Agree With Plan**
Aetna Health	9.7%	10	5	50.0	5	50.0
AmeriChoice **		112	48	42.9	64	47.1
Amerigroup	6.5%	36	23	63.9	13	36.1
AmeriHealth	5.2%	14	1	7.1	13	92.9
Cigna	1.2%	13	8	61.5	5	38.5
Horizon	51.1%	103	43	42.9	60	57.1
Oxford**		18	11	61.1	7	38.9
United**		6	4	66.7	2	33.3
Health Republic	1.6%	2	2	100.0	0	0.0
Total		314*	145		169	

** AmeriChoice (now d/b/a United Healthcare Community Plan), Oxford and United are all owned by UnitedHealth Group. The combined market share is 22.0%.

The table below shows the number of appeals received by the Office of Managed Care (OMC) and the number reviewed by the IURO since establishment of the IHCAP in 1997:

Year	Appeals Accepted by OMC	Appeals Accepted by IURO
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	342	318
CY 2004	337	314
CY 2005	358	343
CY 2006	354	340
CY 2007	306	299
CY 2008	359	355
CY 2009	477	477
CY 2010	424	422
CY 2011	712	702
CY 2012	672	665
CY 2013	548	521
CY 2014	454	446
CY2015	602	581

*

As the table demonstrates, the annual number of appeals filed by covered persons remains low considering the number of residents enrolled in HMOs and other managed care plans (over 3.19 million). However, there has been a continuous increase in appeals, with a marked upturn in appeals starting in 2011. The number of appeals shown on the chart as accepted by OMC, represents the appeals determined to meet the criteria and forwarded to the IURO for review. The number of actual appeals reviewed by the IURO is often lower because of the carrier's decision to cover the service before the IURO initiates its review.

How the Appeal System Works

It is important to remember that covered persons are required to exhaust the carrier's internal appeals process before submitting an appeal for review by an IURO, except in urgent or emergency cases.

During the period covered by this report, all external appeal case reviews were conducted by the two IUROs under contract with the Department --Island Peer Review Organization and Permedion, Inc. The reviews are performed by medical professionals, including specialty physicians appropriate to the area under review. The physician reviewers 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 the fees ranged from $900 to $920 for this reporting period. Consumers pay a $25 filing fee for an external appeal, which is waived in cases of financial hardship. The carrier is required to refund the $25 filing fee to the covered person if the carrier's denial is overturned.

Consumers are allowed up to four months from the date of a carrier's denial of a coverage request to file an external appeal. Under routine circumstances, a decision must be rendered by the IURO within 45 calendar days from receiving the appeal request; however, the IURO can act within a matter of hours in urgent or emergency cases.

Consumer Education

New Jersey law requires that covered persons 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 failed to notify its member of the right to appeal, the Department has taken prompt corrective action.

An Appeal and Complaint Guide for New Jersey Consumers is available on the Department's website at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf. This Guide explains the utilization management appeal process and provides instructions for filing complaints against carriers with the Department. The Department also produces an annual HMO Report Card which includes information on the appeal process. The seventeenth HMO Report Card was made available to the public last year.