# BULLETIN
## OMC-2000-03

**TO:** **All Health Maintenance Organizations (HMOs) Doing Business in New Jersey**

**FROM:** **Elisabeth P. Salberg, RN, CPHQ**
**Director, Office of Managed Care**

**DATE:** **August 15, 2000**

**RE:** **Hospital Length of Stay (LOS) Procedures; Denials and UM Appeals**

The Department of Health and Senior Services (Department) has received a significant number of complaints about the process used to 1) gain approval for additional length of stay, 2) issue denials of hospital days, and 3) request appeal for denials issued. The purpose of this Bulletin is to state the Department's position regarding these processes so that they are better understood by the HMOs and the providers contracted with the HMOs.

### I. The Process Used To Gain Approval For Additional LOS

The process for obtaining extensions of stay beyond those previously authorized should be clearly spelled out in the HMO Utilization Management (UM) Plan and the HMO UM Plan details should be made known to the contracted hospital (N.J.A.C. 8:38-8.1(b)). Both parties need to clearly understand the details of the contracted Utilization Management Plan and New Jersey statute and regulations pertaining to utilization management in order for the system to work appropriately.

### 2. Denials

Denying an acute care day, either through authorizing a lesser level of care or by denying additional length of stay on the grounds that the member is ready for discharge, is a denial of coverage. In accordance with N.J.A.C. 8:38-8.1(b) the HMO must notify both the member and the provider (hospital and attending physician) in writing, in a timely manner, according to the exigencies of the situation. The notification must include the member's appeal rights (N.J.A.C. 8:38-8.4(a)) and an explanation of the clinical criteria upon which the determination is made.

Both the member, or the provider acting on the member's behalf with the member's consent, have the right to appeal the denial (N.J.A.C. 8:38-8.4(a)). The appeal is subject to an expedited review, to which both the member and the provider, when acting on the member's behalf with the member's consent, have a right (N.J.A.C. 8:38-8.5; N.J.A.C. 8:38-8.6(d)).

### 3. Denials – Level of Care

If the HMO has determined that a member, who has been admitted to an acute care facility, requires medically necessary services less than the acute level of care, and the member and/or the provider acting on behalf the member with the member's consent, does not dispute the coverage decision, it is the responsibility of the HMO to identify an available contracted provider offering the required, covered services (N.J.A.C. 8:38-6.3) that will accept its member on a timely basis, according to the exigencies of the circumstances. The Department has determined that "timely basis" should be no more than 24 hours (N.J.A.C. 8:38-8.3(c)). If the HMO cannot identify an available contracted provider, the HMO must pay the provider in accordance with the current contract until an appropriate placement can be made.

If the member and/or the provider acting on behalf of the member with the member's consent, disputes the coverage decision, the appeal is to be subject to an expedited review. Payment issues during processing of the appeal are governed by the terms of the contract between the HMO and the provider. However, it is expected that, if the member's appeal is upheld and the HMO abides by the decision, covered services will be paid for in accordance with the contract. Should the HMO's decision be affirmed, it remains the responsibility of the HMO to identify an available contracted provider offering an appropriate level of care (N.J.A.C. 8:38-6.3) that will accept its member.

## 4. Retroactive Denials

Retroactive denials for covered services where oral or written preauthorization was relied upon, generally reflected by an assigned precertification/preauthorization number, are not allowed except in cases where there was material misrepresentation or fraud (N.J.A.C. 8:38-8.3(d)). Therefore, denials of previously authorized length of stay or downgrading the acuity level of previously authorized care from acute to other levels of care cannot be made retrospectively by the HMO. While HMOs may include statements on authorizations indicating that they do not constitute eligibility determinations, they may not otherwise qualify authorizations so as to permit retroactive denials of covered services.

## 5. Emergency Room Denials

HMO members and plan members subject to the Health Care Quality Act (non-HMO managed care plan members) have the right, as a prudent layperson possessing an average knowledge of health and medicine, to call 911 or go to an emergency room to be screened to determine if an emergency exists if they believe an emergency does exist, without receiving prior approval from their health plan. Retroactive denials of the medical screening and of the tests performed to determine whether or not an emergency exist, are not allowed (N.J.A.C. 8:38-5.3(b)5 and N.J.A.C. 8:38-8.3(d)).

## 6. Appeals - Utilization Management Denials (N.J.A.C. 8:38-8.4 through 8.7)

The Department has received complaints that some HMOs are not allowing the provider to file for an appeal on behalf of the member with the member's consent. As previously stated, both the member and the provider must be notified of all coverage denial decisions (N.J.A.C. 8:38-4). Members, especially those with medical problems, may need the professional expertise and support of a provider to effectively negotiate the appeals process. Therefore, the provider (hospital or physician) has a right to appeal an HMO's decision to deny, limit or terminate a covered health service so long as the provider has obtained the member's consent to appeal on his or her behalf. The provider should be informed of this right on the initial denial notice.

We have received complaints that some providers are obtaining advance blanket consents at admission to be used in case a denial is issued by the HMO. Advance consents do not provide the member an informed basis for appealing a coverage denial. The member may not clearly understand that his or her health plan disputes the medical necessity of the service offered by the provider. The member has purchased (or had purchased on his/her behalf) coverage for medically necessary health care services, and the member's health status and medical condition may be directly affected by the denial, reduction or termination of services.

If the provider is filing the appeal on behalf of the member, the member's consent must be obtained after notification of the denial of coverage by the HMO but prior to the filing of the appeal.

## 7. Hold Harmless

The Department has been asked by providers if appeals are limited to situations where the member can be billed for services. There is no indication in law or regulation that the appeal program exists solely to protect members from the financial consequences of denials (N.J.A.C. 8:38-8.4(a)). The fact that the member may have no financial liability for a service because of the terms of the contract between the provider and the HMO does not alter the member's interest in receiving appropriate, high quality medical care nor does it alter his or her right to be informed about the care provided or the right to exercise his or her appeal rights (N.J.A.C. 8:38-8.3(e), 8.5, 8.6(f) and 9.1(d)3).

## 8. Time Frames for Appeals

Time frames for each stage of the HMO's internal utilization appeal process (for appeals by the member, or the provider acting on behalf of the member with the member's consent) must be within the time frames required by N.J.A.C. 8:38-8.4 through 8.7 and the Health Care Quality Act. These time frames are as follows:

- Initial denial – On a timely basis as required by the exigencies of the situation (N.J.A.C. 8:38-8.3(c)).

- Stage 1 Appeal – 72 hours or less for appeals involving urgent or emergency care and 5 business days for all other appeals (N.J.A.C. 8:38-8.5).

- Stage 2 Appeal – All stage 2 appeals must be acknowledged by the HMO in writing within 10 days of receipt; resolution of urgent or emergency care appeals must be completed within 72 hours; resolution for all other stage 2 appeals shall be completed within 20 business days (N.J.A.C. 8:38-8.6(c) and 8.6(d)); requests for extensions of up to an additional 20 days must be presented to the Department for approval before the end of the original 20 days, with notice to the member and/or provider.

- Stage 3 Appeal (IHCAP) – The member or the provider, acting on behalf of the member with the member's consent, has 60 days following receipt of the HMO's determination of the stage 2 appeal to file for the IHCAP review (N.J.S.A. 26:2S-11).

Failure of the HMO to adhere to any of these time frames allows the member or the provider, if the provider is acting on behalf of the member with the member's consent, to bypass completion of the HMO's internal process and proceed to the IHCAP (N.J.A.C. 8:38-8.6(g)).

**9. Administrative Denials – (Complaint and Appeal System – N.J.A.C. 8:38-3.7)**

Administrative denials (that is, denials issued because a member or provider has failed to follow contracted procedures in accessing services) are not subject to the UM appeal system generally, but may be pursued through the complaint system that HMOs are required to have pursuant to amended N.J.A.C. 8:38-3.7 (formerly N.J.A.C. 8:38-3.6). Providers may bill HMO members when an HMO issues an administrative denial so long as the denial is based on the member's failure to follow the required process, but providers should not bill members when the basis of the denial is the provider's failure to follow a required process pursuant to the provider's agreement with the HMO (N.J.A.C. 8:38-15.2).

The HMO shall notify the member as well as the provider of all denials, administrative denials included. The member, or the provider acting on behalf of the member with the member's consent, has the right to appeal an administrative denial (N.J.A.C. 8:38-3.7(a)).

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