BULLETIN
OMC 2001-01

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

COPY: **All Hospitals in New Jersey**

FROM: **Sylvia Allen-Ware, Acting Director, New Jersey State Department of Health and Senior Services**

DATE: **February 15, 2001**

RE: **Supplement to Bulletins 2000-03 and 2000-04**

The Department of Health and Senior Services ("Department") distributed advisory Bulletins 2000-03 and 2000-04 in August 2000. Since then, the Department has received inquiries regarding those bulletins. Departmental bulletins are advisory documents intended to provide guidance to the industry. This supplemental bulletin is intended to provide additional guidance with respect to some of the issues raised by the previous two bulletins. By issuing these bulletins, the Department has not engaged in rulemaking. The Department encourages the regulated industry to follow the advisory statements as issued in the bulletins with the understanding that the industry can only be held to standards set forth by the applicable governing statutes and regulations.

The bases for the Department's position on some issues contained in Bulletins 2000-03 and 04 follow.

Bulletin 2000-03

In Section 2, the Department indicated that authorizing a lesser level of care or denial of additional lengths of stay are coverage denials constituting utilization management decisions. This position is based on N.J.A.C. 8:38-8.3(a) and (b), as well as language at N.J.A.C. 8:38-3.7(c), 8:38-8.4(a), and N.J.S.A. 26:2S-4a and 11a.

In Section 2, the Department indicated that denials must be communicated in writing to providers and members. It may be noted that, for initial decisions, denials are required to be in writing upon request, pursuant to N.J.A.C. 8:38-8.3(e). (See treatment of notice of denials upon appeal below.) The Department may consider promulgating rules requiring that all denials be memorialized.

In Section 3, the Department indicated that the movement of a member/patient from one care setting to another should be accomplished within 24 hours from when the decision is made that a change in the care setting is appropriate. This position is advisory, and based on the definition of urgent care at N.J.A.C. 8:38-1.2, and adequacy of the provider networks (N.J.A.C. 8:38-6) for health care services provided in all care settings (N.J.A.C. 8:38-5).

In Section 3, the Department indicated that payments for the care setting in which care is rendered should be based on the contracted rate (if any) between the HMO and the health care provider. This position is based on N.J.A.C. 8:38-15.2, particularly 15.2(b)5 and 6.

In Section 4, the Department indicated that retroactive denials for covered services where oral or written authorization had previously been given and relied upon are impermissible,

except for circumstances related to fraud or material misrepresentation, and that qualifiers that attempt to permit a retroactive denial are also impermissible. This position is based on N.J.A.C. 8:38-8.3(d) as well as N.J.S.A. 26:2S-6b.

In Section 5, the Department indicated that retroactive denial of medical screenings and tests that are necessary to determine whether an emergency exists performed in an emergency department is impermissible. This position is based on N.J.A.C. 8:38-5.3(b)(5).

In Section 6, the Department indicated that providers must be given the opportunity to make an appeal on behalf of a member, with the member's consent. This position is based on N.J.A.C. 8:38-8.4(a) and N.J.A.C. 8:38-3.7(c), in addition to N.J.A.C. 8:38-3.7(e), 8.3(e), 8.5 and 15.2(b)2 and 3.

In Section 6, the Department indicated that notice must be given to providers and members of adverse determinations. This position is based on the following: N.J.A.C. 8:38-8.3(b) for notice of initial decisions to providers (N.J.A.C. 8:38-8.3(e) requires notice to members or providers in writing upon request) as well as N.J.A.C. 8:38-8.4(a)[1] for notice to members or providers appealing on behalf of members (with member consent), as well as N.J.A.C. 8:38-8.1(b)[2]. The Department may consider promulgating rules to require that written notice of an initial adverse determination be provided to members.

In Section 6, the Department indicated that the provider's right to appeal on behalf of a member is prefaced on the provider obtaining consent following notice of an adverse utilization management determination (that is, informed or specific consent). This position is based on the provisions of N.J.A.C. 8:38-8.4, 8.5, 8.6(a), 8.7(a), 10.2 and 15.2(b)11. In addition, see also the discussion in the adoption of amendments to N.J.A.C. 8:38 at 32 New Jersey Register 1559.

Bulletin 2000-04

In section 3, the Department indicated that HMOs should process certain challenges[3] to denials of services or treatments as utilization management appeals, whether or not the HMO classified the denial as a utilization management determination in the first instance. This position is based on the definition of utilization management at N.J.S.A. 26:2S-2 (and N.J.A.C. 8:38-1.2) and N.J.S.A. 26:2S-11a, as well as N.J.A.C. 8:38-8.3(b). Some discussion in this regard is contained at 31 New Jersey Register 1566, with respect to adoption of new rules at N.J.A.C. 8:38A. In addition, there are statutes that require special consideration of services or treatments that may otherwise be classified as experimental or investigational for certain illnesses. See, for instance, N.J.S.A. 26:2J-4.5 and 4.8.

[1] N.J.A.C. 8:38-8.4(a) primarily addresses the right to appeal UM determinations, with reference to later rules on appeal of adverse determinations at various stages.

[2] N.J.A.C. 8:38-8.1(b) primarily addresses the requirement that utilization management determinations be based on clinical criteria and protocols meeting certain standards, including ready availability, upon request, to members and participating providers.

[3] Specifically, when an HMO denies coverage or benefits for a service or treatment because: (1) the HMO believes the service or treatment is cosmetic, but the member or provider contends that it is medically necessary; (2) the HMO believes the service or treatment is a dental service, but the member or provider contends that it is a medical service; (3) the HMO believes the service or treatment is experimental or investigational (or at least is not a type of treatment required to be covered by law or other agreement to which the HMO is a party), but the member or provider contends that it is now accepted practice (or contends that it should be covered because of law or other agreement to which the HMO is a party); or, (4) the HMO believes that the service or treatment is for a preexisting condition (for which a preexisting condition period remains to be satisfied), but the member or provider contends that the condition was not preexisting.