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BANKING AND INSURANCE

DIVISION OF INSURANCE

Health Maintenance Organizations

Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations

Adopted Amendments: N.J.A.C. 11:24-1.2, 3.7, and 8.3 through 8.8 and 11:24A-1.2, 3.2, 3.4, 3.5, 3.6, and 3.7

Adopted Repeal: N.J.A.C. 11:24-8.9

Proposed: September 19, 2011 at 43 N.J.R. 2411(a).

Adopted: January 12, 2012 by Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Filed: January 12, 2012 as R.2012 d.035, **with substantial and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-54, 26:2J-21, and 26:2S-1 et seq.

Effective Date: February 6, 2012

Expiration Date: February 15, 2015, N.J.A.C. 11:24;

March 1, 2018, N.J.A.C. 11:24A.

Summary of Public Comments and Agency Responses:

The Department received comments from New Jersey Association of Health Plans (NJAHP), Aetna, the Medical Society of New Jersey (MSNJ), the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA), the Law Office of Jeffrey Randolph, LLC

on behalf of the Association of New Jersey Chiropractors, Inc. (ANJC), the New Jersey Hospital Association (NJHA), and the Raritan Bay Medical Center (RBMC).

1. COMMENT: There were several comments of a general nature regarding the proposed amendments and repeal. Many commenters expressed appreciation of the Department's efforts to bring existing State law appeal rights into compliance with the requirements of the Patient Protection and Affordable Care Act, Pub. Law 111-152 (PPACA, Affordable Care Act, or ACA). One commenter applauded the Department's efforts to improve communication with consumers and providers, and to ensure sufficient time for informed appeals requests to be submitted. The commenter stated that these positive changes, along with the amended time frames for HMOs and independent utilization review organizations (IUROs), show promise for facilitating an efficient appeal process that will provide better protection and care for consumers. To further ensure the effectiveness of the regulation and maximize the potential benefits for consumers, the commenter requested transparency in the appeal process, a requirement for HMOs to report statistics and monitoring of HMOs based on this data, and the development of a single procedure so that providers would not need to be familiar with four different processes.

RESPONSE: The Department appreciates the comments supporting the proposal. With respect to the comment requesting transparency of the appeals process and a requirement for HMOs to report statistics and monitoring of HMOs based on such data, information on the number, category and outcome of prior authorization requests, as well as stage 1, stage 2 and external appeals, is reported annually by HMOs as part of the reporting required by N.J.S.A. 26:2J-9. HMOs also annually submit vendor oversight reports. These reports are reviewed by Department staff and are followed up where necessary. Moreover, semi-annual reports on the

Independent Health Care Appeals Program (external appeals) that summarize the number of reviews conducted and medical specialties affected, the findings and recommendations of the IUROs, and other information are already prepared by the Department as required by N.J.S.A. 26:2S-14.

With respect to the request for a single appeal process, the Department notes that the New Jersey Legislature created a specific binding payment arbitration process for provider payment disputes not involving medical necessity and a separate IURO process for member disputes involving medical necessity. In addition, the Affordable Care Act creates an appeals mechanism for adverse benefit determinations for both insured and self-funded plans. The Department appreciates the commenter's confusion over the multiple types of appeal processes, but does not have the authority to override State and Federal law and create a single appeal process for all types of member and provider disputes.

2. COMMENT: One commenter stated that moving individual members to a single level of appeal is required by the Federal rules, but now that benefits-based appeals are not subject to external review, individual members will be given a single level of appeal on benefits-based denials, and then be sent on to the Department if they are still not satisfied with the outcome. This may have unintended results, and may result in many members reaching out to the Department for relief. This may create a *de facto* second-level review albeit coming about through a Department-initiated follow-up inquiry with the plans on behalf of the members.

RESPONSE: The Department does not understand the comment. Disputes that are subject to external review are those that involve medical judgment. The Department further does not understand what the commenter means by the terms benefits-based denial and benefits-based appeals.

3. COMMENT: One commenter stated that the proposal's economic impact to physicians was not noted in the preamble in any way. Citing the American Medical Association's studies, the commenter indicated that up to 14 percent of physician revenue is expended on administrative tasks. The commenter asked that the Department be mindful of the continuing administrative burden on physicians when they are attempting to assist patients to obtain medically necessary care. The commenter stated that physicians and their staff are always involved in the appeal of utilization management (UM) decisions (now adverse benefit determinations), and that physicians are financially harmed when insurers do not make payments on claims for services rendered, even when services have been rendered in good faith and the denial may be based on a paperwork issue.

The commenter expressed its concern that decisions concerning member or group ineligibility, rescission, and the application of contract exclusions or limitations are exempted from the appeal process. While recognizing that these decisions are not perfectly suited to UM decision-making, the commenter stated that ineligibility and rescission decisions (followed by recoupments) that are made after physicians have rendered significant medical services, in good faith, and through no fault of their own to establish eligibility, must be stopped. It is fundamentally unfair for insurers and patients to avoid payment for medical services rendered in good faith because the insurer later determines ineligibility. The payment obligation is squarely on the patient and insurer, but the physician is most often the one who pays. The commenter is seeking the Department's assistance in addressing this issue as soon as possible.

The commenter stated that the Department's rules on health insurance identification cards have been helpful to physicians and staff in determining patients' plans. However, the commenter stated that there is still a challenge in determining plan rules and the appropriate appeal route. The commenter urged the Department to require insurers to indicate on the

explanation of benefits (EOBs) the appropriate appeal route for any claim. Also, the commenter stated that the EOB should specify the insurer's website page on which all appeals information can be found, as well as the phone number for a contact person to assist.

Finally, the commenter stated it is seeking clarification on the following questions:

1. When will the regulated community know whether the proposed changes are accepted?

2. When will the new rules be implemented?

3. Will the Department clearly identify all of the plans to which these rules will apply?

4. How will the Department ensure that physicians receive notice from insurers of the rule changes?

RESPONSE: The Department recognizes that providers of all types are involved in the appeal process. These rules conform the State regulations regarding utilization management and appeals to the Affordable Care Act. Moreover, denials that do not involve medical judgment, such as denials based on member ineligibility, have never been subject to external review. There are other means to appeal such decisions, including the provider payment arbitration process.

The request to require information on EOBs is beyond the scope of this proposal, and the commenter should note that DOBI rules do not address EOBs at all. With respect to the four questions, the proposal when adopted will appear in the New Jersey Register and will be effective on adoption. These rules apply to the same plans as all Department of Banking and Insurance (DOBI) rules (that is, insured health benefit plans issued in New Jersey). Insurers will notify providers as required by N.J.S.A. 17B:30-51.

4. COMMENT: Two commenters questioned some of the proposed definitions. One commenter stated that while it understood that the proposed definition of "adverse benefit determination" is consistent with the Federal rules implementing PPACA, it had operational

concerns. Specifically, the commenter stated that a "denial, reduction or a failure to make payment for a benefit . . . resulting from utilization management" is not an adverse benefit determination. A UM determination that lowers a level of care or a part of an inpatient stay is not a denial of benefit. For example, coverage may be denied of an acute care-based claim but provided for care delivered in a sub-acute care setting if the patient is transitioned for drug therapy, but the drug therapy still would be a covered benefit. The commenter stated that the term "benefit" should be replaced with "medical necessity" or the Health Claims Authorization, Processing and Payment Act's (HCAPPA's) (P.L. 2005, c. 352) definition of UM, which would meet the Department's intent if included in the context of the definition: "system for reviewing the appropriate and efficient allocation of health care services according to specific guidelines . . . [.]"

RESPONSE: The Department disagrees. An adverse benefit determination as defined in these rules includes a failure to make payment, in whole or in part, based on application of utilization review. Therefore, a payment for a hospital stay based on a sub-acute, rather than an acute, care rate is an adverse benefit determination. Moreover, use of the term adverse benefit determination is mandated by the ACA.

5. COMMENT: Two commenters were concerned about the practical implications surrounding the proposed definition of "claim" due to language stating that a claim is " . . . for payment relating to health care services or supplies <u>covered</u> under a health benefits plan . . . [.]" The commenters stated that while they support a payer's right to define the benefits covered under its plan offerings, there are operational implications that the proposed amendments do not go far enough in addressing. Specifically, it is the payer that has access to the information concerning what services are covered under a health plan. However, payers often authorize services without first ensuring that they are indeed covered. The commenters

stated that this proposal affords the Department the opportunity to resolve the long-standing issue created under HCAPPA provisions related to "authorization." As defined in Section 3 of HCAPPA, a utilization management determination "satisfies the requirements under the member's health benefits plans for medical necessity." However, in Section 5 payers are required to respond to a provider's request for authorization by approving or denying the request "based on the covered person's health benefits plan." The commenters stated that the first provision references medical necessity, which may be determined without regard to whether the services are covered under the plan, while the second requires a review of the member's benefits plan. This distinction is important because a carrier will frequently approve a service based on medical necessity, but later deny it because it is not a covered service under the member's plan. According to the commenters, the rule as proposed allows a provider to submit a claim only in instances when it is a covered service, but with no knowledge of what is covered under a subscriber's plan. The commenters requested that the Department clarify that authorization or denial of a service must consider both medical necessity and whether the service is covered under the plan.

RESPONSE: The changes made to the definition of claim are intended to conform that definition to the Federal definition of claim for benefits at 29 CFR 2560.503-1(e), which refers to a “request for a plan benefit or benefits made by a claimant.” The definition of claim is not relevant to the commenter’s argument that pre-authorization of a service by a plan means that the plan must pay for the service when it is rendered. On this issue, the Department notes that N.J.S.A. 17B:30-53 only prohibits a plan from denying payment for services that were preauthorized based on medical necessity. The carrier is free to deny payment if the member was not covered by the plan on the date of service or for other reasons not related to medical

necessity (for example, the member has not yet satisfied his deductible or member has reached the maximum benefit).

6. COMMENT: Two commenters were concerned about the proposed definition of "urgent care claim." One of the commenters stated that the proposed definition appears to attempt to define urgent care services as emergency services by allowing that an urgent care claim includes care that "could seriously jeopardize the life or health of the covered person." Further, the proposed definition seems to predominantly be taken from the definition of emergent care in separate regulations. Given that emergency care is already clearly defined by law, the commenter is uncertain of the need to add a new definition for urgent care claim in the regulations. The commenter stated that if it is the Department's intent to incorporate language that allows for instances whereby a provider makes a decision based upon their knowledge, that language can be incorporated more effectively into the definition of emergency as currently defined at N.J.A.C. 11:24-1.2.

The commenters additionally stated that it appears the new definition endeavors to address the time frame for the completion of benefit determinations as included in the Federal rule. However, it fails to address stricter time frames established by HCAPPA for emergency and inpatient hospital care. Specifically, in Section 5 of HCAPPA, in instances where a covered person is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, a determination must be made no later than 24 hours following the request. The commenters strongly urged the Department to remove the proposed language for the definition of "urgent care claim" and align the regulations with HCAPPA to include a reference to the 24-hour time frame. One of the commenters additionally requested that the Department amend proposed N.J.A.C. 11:24-8.3(c)1i as related to "pre service claims."

RESPONSE: The Department is using the definition of urgent care found in the Federal regulations at 29 CFR 2560.503-1(m)(1). The term is used only with respect to the obligation to render benefit determinations within 72 hours in cases involving urgent care. The rule does not conflict with or override N.J.S.A. 17B:30-52 with respect to the obligation to decide an authorization request for persons currently receiving inpatient hospital care within 24 hours. Rather, the more stringent 24-hour requirement applies when persons are confined to a hospital and thus both the Federal and State requirements are met.

Moreover, the 24-hour rule at N.J.S.A. 17B:30-52a(2) applies only to the initial request for authorization, and not to the period within which to decide a stage 1 or stage 2 internal appeal or an external appeal. Under current State law, stage 1 and stage 2 appeals involving urgent or emergent care (including all situations in which the member is confined as an inpatient) are to be decided in no more than 72 hours.

The Department does not believe that N.J.A.C. 11:24-8.3(c)1i needs to be amended as requested by one of the commenters. N.J.A.C. 11:24-8.3(c)1 addresses urgent care claims. It is evident that the definition of urgent care claim in N.J.A.C. 11:24-1.2 includes pre-service claims.

7. COMMENT: Two commenters commented on proposed N.J.A.C. 11:24-8.3(d). One commenter supported the proposed amendment of the existing rule text prohibiting a carrier from reversing a UM decision where a provider has relied on the written or oral authorization of the HMO. The commenter stated that it believes this provision will provide more certainty for health care providers who reasonably rely upon preauthorization of services by a carrier, as well as promote accountability of the carrier for its decisions communicated and relied upon by health care providers. Another commenter expressed concern about the Department's use of "utilization management determination" in this provision. The commenter stated that, as the

Department points out in the proposal Summary, the amendments are predicated upon the broader definition of "adverse benefit determination" as established by Federal requirements, but did not use that term in this provision. Instead, the Department used the term "utilization benefit determination" which is not defined within the rule. The commenter recommended that the Department incorporate the adverse benefit determination terminology in this provision to ensure consistency.

RESPONSE: With respect to the comment regarding the obligation of carriers to pay for services that were pre-authorized, the Department directs the commenter to the Response to Comment 5. Regarding the comment concerning the Department's use of the term "utilization benefit determination" rather than "adverse benefit determination," the commenter is incorrect. The Department used the term "utilization management decision." Utilization management is defined in Chapter 24, and is a system for determining which health care services will be reimbursed, covered, paid for, or otherwise provided under a health benefits plan. An adverse benefit determination as defined in Chapter 24 may result from a health plan's application of its utilization management system. Accordingly, it is not appropriate to replace the term "utilization management determination" with "adverse benefit determination" in all instances. The heading of Subchapter 8 is “Utilization Management.” The subchapter was always intended to be limited to utilization management determinations, and the proposed amendment makes such intent clear.

8. COMMENT: Two commenters were unclear concerning proposed N.J.A.C. 11:24-8.3(e), which includes language that requires written notice of a determination to deny coverage or authorization for services to be provided within two business days. The commenters stated that this seems to undermine the language at N.J.A.C. 11:24-8.3(c)1i, ii, and iii, which clearly outline the time frames in which determinations must be made based upon

the medical exigencies of the situation. The commenters urged that the proposed language be removed to ensure there is no confusion regarding the time frames carriers are responsible to meet.

RESPONSE: Utilization management decisions, particularly in urgent care cases including cases where person are hospitalized, are made orally and may be followed up in writing. The rule's current language states that written notice would be provided only upon request of a member or provider. The amended language at N.J.A.C. 11:24-8.3(e) is intended to advise carriers that they will now be required to provide a follow-up written notice within two business days after making any of the determinations set forth at N.J.A.C. 11:24-8.3(c)1.

9. COMMENT: Two commenters were concerned about the proposed amendments to N.J.A.C. 11:24-8.4. The commenters stated that the proposed language makes a distinction between appeals processes for group and individual plans. Absent clear definitions regarding what constitutes group and individual plans, consumers and providers with consumers' consent may not be certain of which process to utilize. That lack of certainty could potentially lead to the loss of a consumer's appeal rights, for instance, when the wrong process is accessed and deadlines for the appropriate process are missed. The commenters urged the Department to include clear definitions of group and individual health plans, and indicate any instances in which a plan may not be eligible for either State process (for example, self-funded group health plans). N.J.A.C. 11:24-1.1 sets forth the scope of application of these rules. Accordingly, the Department does not believe it is necessary to set forth all the plans that are exempt from compliance with the rules.

RESPONSE: "Individual health benefits plan" is defined at N.J.S.A. 17B:27A-2 and "group health contract" is defined in the HMO rules at N.J.A.C. 11:24-1.2. The Department does not believe that it is necessary to repeat such definitions in these amendments.

10. COMMENT: One commenter stated that it supported the expansion to 180 days of the time frame at proposed N.J.A.C. 11:24-8.4(a) for subscribers and/or providers to appeal adverse benefit determinations. The commenter stated that the prior, shorter time frames were too restrictive and this new time frame comports with the time frame for submission of claims for health care providers who take assignment of benefits from their patients.

RESPONSE: The Department appreciates the support for this change.

11. COMMENT: One commenter stated that proposed N.J.A.C. 11:24-8.4(c) provides that new evidence or rationales developed or generated by the plan must be provided to the member sufficiently in advance of a decision of an adverse benefit determination at stage 1 or 2 of the appeals process to allow the member to respond to the new evidence/rationales prior to the determination. The commenter stated that the Federal requirement only provides that this disclosure needs to occur prior to the *final* internal adverse benefit determination, which in New Jersey State terminology would be at stage 1 for individual plan members and stage 2 for group plan members. Requiring this disclosure in advance of stage 1 and 2 appeals for a group member would be logistically challenging and unnecessarily redundant. The commenter stated that it believed the Federal rules place the proper balance between the need for members to be informed about new information on their appeal and the logistics of compliance with these rules, which may otherwise delay the reaching of a decision within the proper time frame. The commenter requested that the proposed language merely reflect the balance reached and required by Federal law.

RESPONSE: Current State law does not require that carriers disclose new evidence or rationales at any time during the stage 1 or stage 2 appeal determinations. The proposed rule changes, as explained in the Summary of the proposal, were intended to add the requirement to disclose such information to the extent required by the Federal rules, and were not intended

to expand upon said obligation to disclose. Through drafting error, the duty to disclose in the proposal is greater than required by the Federal regulations. As stated by the commenter, complying with the time frames as proposed would likely delay the carrier's reaching a decision within the proper time frame. N.J.A.C. 11:24-8.5 and 11:24A-3.5 require HMOs and other carriers to conclude internal stage 1 appeals within 72 hours in the case of urgent or emergency care appeals and five business days in the case of all other appeals. It would be logistically impossible for carriers to comply with those existing time frames, while at the same time complying with the new Federal requirement proposed at N.J.A.C. 11:24-8.4(c) and 11:24A-3.5(f) to provide new or additional evidence or rationale to the member or covered person sufficiently in advance of the date on which the carrier's determination is made in order to give the member or covered person a reasonable opportunity to respond prior to that date. There simply would not be sufficient time for the member or covered person to respond prior to the deadline for the carrier's determination, and the appeals process intended to benefit consumers would instead provide no advantage. Moreover, as noted by the commenter, the duty to disclose at every level of appeal will result in duplicative disclosure and greater administrative expense. Accordingly, the Department is amending N.J.A.C. 11:24-8.4(c) and 11:24A-3.5(f) to clarify its intent to mirror the Federal rule requirement that the obligation to provide new evidence or rationale occurs only at the final level of internal appeal.

12. COMMENT: One commenter stated that the language proposed at N.J.A.C. 11:24-8.4(e) should be moved to N.J.A.C. 11:24-8.5 and 8.6 because for pre-service denials, the claims amount and coding would not be known. The provision should require written acknowledgement of the appeal, including name, address and telephone number of the individual designated by the HMO to render a decision. The notice of a determination on an

appeal must also include the detailed reasons for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

RESPONSE: The rule requires that claim amount be included if applicable. Moreover, pre-service requests often do include CPT codes. This section deals only with the Federal requirement that initial adverse benefit determinations and adverse benefit determinations following internal appeals be culturally and linguistically appropriate and contain the information required by the Federal rules as set forth in this section. State law, specifically N.J.S.A. 26:2S-6.b.1, requires that utilization management decisions to deny, reduce, or terminate benefits based on medical necessity be made by a physician. State law does not require that such physician be identified. The proposed rule requires that the adverse benefit determination identify the reason and the standard used by the payer in making the adverse benefit determination as required by the Federal rules. State law at N.J.S.A. 17B:30-51 already requires payers to post all internally produced clinical criteria and to identify all commercially produced clinical criteria guidelines used to determine medical necessity.

13. COMMENT: Several comments were received on proposed N.J.A.C. 11:24-8.4(f), which requires an HMO to provide continued coverage of an ongoing course of treatment pending the outcome of a stage 1 internal appeal, a stage 2 internal appeal, and an external appeal. One commenter supported the proposed provision because it will promote continuity of care and protect the doctor-patient relationship during a course of continued care. Another commenter asked whether the Department has a definition of "ongoing treatment," and stated that there have been requests to clarify this requirement under the Federal health care reform. Another commenter stated that the proposed language does not clearly limit the requirement to approved concurrent care situations only, as is the case in the Federal Department of Labor rules. The commenter stated that the proposed language overstates the requirements as set

forth in the new proposed Federal regulations, and requested that this change be clarified to limit it to circumstances as described in 29 CFR 2560.503-1(f)(2)(ii). One commenter stated that the proposed language is silent on a key aspect of the process -- financial liability in the event the adverse decision is upheld. The commenter requested that the Department clarify the proposed language to identify the anticipated party to be held financially responsible in instances where an adverse benefit determination is upheld on appeal.

RESPONSE: The Department appreciates the support for this change. The Department is reluctant to define "ongoing treatment" until such time as the Federal regulations define such term. With respect to the comment that the obligation to continue coverage pending appeal is limited to approved concurrent care, the Department notes that 29 CFR 2560.503-1(f)(2)(ii) deals with the timing of benefit plan determinations in cases where the plan has approved an ongoing course of treatment provided over a period of time or number of treatments. It does not explicitly limit the obligation imposed by the Federal regulations with respect to the requirement to provide continued coverage pending the outcome of an appeal. With respect to the comment asking about financial responsibility if the adverse benefit determination is upheld on appeal, the obligation to provide continued coverage pending the outcome of an appeal does not depend on the decision on appeal. Thus if the carrier is obligated to continue coverage pending the outcome of an appeal, it is responsible to pay plan benefits for such services until the appeal is decided regardless of whether the outcome of the appeal is to uphold or to reverse the adverse benefit determination.

14. COMMENT: There were several comments on proposed N.J.A.C. 11:24-8.5. Two commenters stated that the proposed amendment extending the time for determining stage 1 appeals from five business days to 10 calendar days should be changed to 15 calendar days to be consistent with the Federal Department of Labor's (DOL's) requirements for both levels of

appeal. The commenter added that the DOL permits 30 days to resolve non-urgent pre-service appeals, but where two levels are provided, the time is split between the levels (that is, 15 calendar days per appeal). The commenter further stated that under existing New Jersey requirements, carriers are permitted 20 business days to conclude a stage 2 appeal (for non-urgent matters). However, to comply with the DOL's time frame, carriers must respond to the second level within 15 calendar days. The commenter stated that while the 10-day time frame is helpful, it still will not allow enough time to be compliant with the "decision based on new information" workflow. In that scenario, as outlined by PPACA, once a carrier makes a determination to uphold the denial based on new information, the carrier must reach out to the member and allow them to submit any new evidence to support the benefits being released. During this time, the clock does not stop.

Two commenters raised concerns about the 72-hour time frame in which to make a determination regarding an urgent or emergency care appeal decision. The commenters stated that Section 5 of HCAPPA requires that these determinations be made within 24 hours. Further, Section 5 of HCAPPA states that "if a payer fails to respond to an authorization request within the time frames established . . . the hospital or physician's request shall be deemed approved and the payer shall be responsible." Therefore, it is imperative for both the providers and the plans to have consistency between the regulations and the law to ensure there is no potential for liability. The commenters requested that the Department ensure that the 24-hour rule, as required by HCAPPA for the determination of an urgent or emergent appeal, be appropriately noted throughout the rule proposal.

RESPONSE: The Department does not believe that it is prudent to further extend the time frame in which carriers have to determine stage 1 appeals as requested by the commenter. Stage 1 appeals have been required to be decided in five business days since

1997. In response to the procedural requirements imposed by the Affordable Care Act on carriers in deciding internal appeals, the Department proposed an extension of this period to 10 calendar days. The Department does not believe that it is necessary to extend further the time period within which carriers must decide stage 1 appeals based on speculation about the additional time that may be needed to provide any additional evidence or rationale relied upon. The Department is concerned that delay may harm consumers without a demonstrated justification for the need for an extension. With respect to the comment on the 72-hour time frame, the Department directs the commenters to the Response to Comment 6.

15. COMMENT: Two commenters supported the proposed language at N.J.A.C. 11:24-8.6(b) requiring that appeals panels include same specialty physicians who are licensed to practice in New Jersey. One of the commenters added that the rules may be further strengthened by including an additional provision requiring that the same specialty reviewer be actively practicing in that specialty (not retired or inactive) for at least five years, similar to the requirement for expert qualification in a medical malpractice civil case (see N.J.S.A. 2A:53A-27). This additional language would ensure the competency of the reviewer and improve the quality of decisions made by the reviewer, which may be lacking where reviewers do not actively practice or have significant practical experience in the area of specialty being reviewed.

One commenter requested clarification on the proposed language change. The commenter indicated that it always includes the specialty match review findings in the panel hearing and the findings are part of the deliberation/decision making process. The commenter stated that this language change implies that carriers need to have a specialty consultant on the panel, which would increase costs because the consultants will complete the specialty review and attend panel hearings. The commenter added that it will also impact its internal

procedures and add some complexity to scheduling the panels (that is, coordinating with the consultant's schedule).

Another commenter stated that the Federal rules do not go as far as the proposed language change, nor do the National Committee for Quality Assurance (NCQA) or URAC accreditation rules, and this change will be extremely complex, logistically problematic and costly to administer, without any discernible benefit since peer match opinions are typically obtained by NCQA or URAC accredited plans as part of the appeals process and will now need to be shared with members under the new rules because the peer-matched opinions are new evidence generated by the plan in the course of the appeal. The commenter requested that peer-matched participation at stage 2 remain at a member's request only. The commenter added that a review of other states' requirements identified only two that require inclusion of a specialty-match physician.

RESPONSE: The Department appreciates the support for this change. Under the Department's current HMO rules at N.J.A.C. 11:24-8.6 and Health Care Quality Act (HCQA) rules at N.J.A.C. 11:24A-3.5, a consulting practitioner or professional in the same specialty as would typically manage the case at issue would be required to participate in the panel's review of a particular case if the member or covered person and/or their provider appealing the stage 1 determination requests such participation. However, many consumers or their providers do not currently make such a request. Accordingly, the Department believed that requiring participation by a same-specialty provider would provide consumers with a more meaningful stage 2 review. The Department's review of the comments opposed to the amendment clearly indicates that the benefit to consumers may be minimal, while the costs and administrative burden imposed on health plans would be significant. As stated by the commenters, the proposed amendment would increase the health plans' costs because the same specialty

consultants would need to complete the specialty review and attend the panel hearings in all stage 2 appeals, and these increased administrative costs would ultimately be passed along to consumers. The commenters also stated that the proposed amendment would be extremely administratively burdensome to the health plans. The commenters pointed out that NCQA and URAC accredited health plans currently typically include specialty match review findings in their deliberation/decision making process and, under the new Federal requirements, these findings will need to be provided as new evidence to appellants during the course of the appeal. The commenters further indicated that the proposed amendment would require the health plans to consider the providers' availability when scheduling hearings. The commenters additionally noted that only two states require the inclusion of a same-specialty physician on a stage 2 appeal panel, and that such a requirement goes beyond the Federal rule requirements. In considering all the comments received on this proposed amendment, the Department determined that the potential benefit to consumers would not outweigh the cost and administrative burden placed on health plans. Accordingly, the Department is not adopting the requirement to have a same specialty provider on the panel, and is maintaining the current text of both the HMO and HCQA rules, which requires that the panel have access to consultant providers who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed provider as may be mutually agreed upon by the parties, and include such providers on the stage 2 panel at the request of the covered person or the provider.

The Department believes that this change may be made upon adoption pursuant to N.J.A.C. 1:30-6.3 because it does not effectively destroy the value of the original notice of the Department's intent that these rules mirror the Federal requirements. While the proposal would have required that a same specialty provider be physically present on the panel, the revision

will continue to permit the panel to consult such a provider, and the member or covered person who is appealing an adverse benefit determination to request participation of such a provider. The revision will slightly modify the method by which a same specialty provider would participate in an appeal, but will not substantially affect the parties participating in the appeal or its final outcome.

The Department additionally does not believe that it is necessary to expand this requirement to require that the specialist be in active practice for at least five years as suggested by one of the commenters. There is no State or Federal law that requires that physicians participating in UM decisions or appeals be in active practice for five years. Moreover, the Department has had no issues with the quality of the physicians who currently participate in UM appeals, and sees no reason to add such a requirement.

16. COMMENT: Three commenters requested that the 72-hour time frame referenced at N.J.A.C. 11:24-8.6(d) be modified so that HMOs are required to comply with the 24-hour HCAPPA requirement discussed in an earlier comment.

RESPONSE: The Department directs the commenters to the Response to Comment 6.

17. COMMENT: Several comments were submitted concerning the proposed amendments at N.J.A.C. 11:24-8.6(f), which relieves a member and/or provider of his or her obligation to complete the HMO internal review process and, at his or her option, proceed directly to the external appeals process under certain circumstances. One commenter stated that it supported the proposed amendment deleting current language (at subsection (e)) permitting a carrier to extend its review for up to an additional 20 business days, and the proposed new language at subsection (f) permitting a member and/or provider to proceed directly to the external appeals process if the carrier fails to comply with any of the deadlines for completion of the internal adverse benefit determination appeals unless the violation does

not cause, and is not likely to cause, prejudice or harm to the member and/or provider, so long as the carrier demonstrates that the violation was for good cause or due to matters beyond the control of the carrier, and that the violation occurred in the context of an ongoing, good faith exchange of information between the carrier and the member and/or provider, and is not reflective of a pattern or practice of non-compliance by the carrier.

All of the commenters expressed some concern with the proposed language. The commenters stated that while it appears the Department attempted to address concerns with regard to patient safety, the allowance that an HMO must merely believe it is not likely to cause prejudice or harm is simply not strong enough. The commenters further stated that the language fails to define "good faith," and does not identify who will determine if the violation is indicative of a pattern or practice (that is, the Department or an independent review organization). The commenters further stated that the proposed language is made even more unclear by the proposed removal of N.J.A.C. 11:24-8.9, which would appear to indicate that the Department will no longer be reviewing the HMO reports to determine patterns of non-compliance. The commenters stated that proposed N.J.A.C. 11:24-8.6(f)1i appears to put the onus on the member and/or provider to police the HMO for violations by allowing for a member and/or provider to request a written explanation of the violation, which includes another time frame of 10 days within which an HMO may respond. The commenters strongly urged the Department to rescind the proposed language at N.J.A.C. 11:24-8.6(f) and maintain the language at N.J.A.C. 11:24-8.9 to preserve the consumer protections established under the original rule.

RESPONSE: The Department appreciates the support for this change. The language in N.J.A.C. 11:24-8.6(f) is required by the Federal regulations. The Department repealed the language in N.J.A.C. 11:24-8.9 that deals with reporting reasons for an HMO's rejection of the

IURO's recommendations because adverse IURO determinations are binding on the HMO and cannot be rejected.

18. COMMENT: One commenter supported the new language at N.J.A.C. 11:24-8.7(k) mandating that a carrier provide benefits (including payment on the claim) pursuant to the IURO's determination without delay regardless of whether the carrier intends to seek judicial review of the decision. However, the commenter indicated that it does not support the proposed new language requiring that an IURO's determination be binding on the carrier *and the member and/or provider*, except to the extent that other remedies are available to either party under State or Federal law. The commenter stated that it does not believe there is sound or justifiable policy to change the current provision. According to the commenter, providers that have been served with facially deficient IURO determinations have been able to obtain review from the Department and obtain a prompt remedy to such obviously deficient determinations. This remedy will no longer be available to a provider, and they will be required to retain an attorney and begin the long and costly process of legal review through the State or Federal court systems if they wish to address a deficient IURO decision. The commenter requested that the Department remove the new language making IURO decisions binding upon members and/or providers and maintain the current regulation which makes such determinations only binding on the carrier.

RESPONSE: The language the commenter objects to is required by the Federal regulations, which provide that the external review process must be binding on the insurer "as well as the claimant except to the extent that other remedies are available under state or federal law" (29 CFR 2590.715-2719(c)(2)(xi).

19. COMMENT: One commenter supported the proposed amendment to N.J.A.C. 11:24-8.7(b) that requires the carrier to provide a subscriber and/or provider with a minimum four-

month period, rather than 60 days, from receipt of the final internal adverse benefit determination to request an IURO appeal.

RESPONSE: The Department thanks the commenter for its support.

20. COMMENT: Two comments were received regarding the proposed amendments to N.J.A.C. 11:24-8.7(c). One commenter supported the cost reimbursement provision to subscribers if the final internal adverse benefit determination is reversed by the IURO. The commenter stated that this will promote fairness in the process and reimburse subscribers for validly filed IURO reviews.

One commenter stated that in most instances, the financial responsibility of filing an appeal is met by the provider on behalf of the member. Moreover, providers are obligated to do so under HCAPPA. Specifically, HCAPPA includes language that "the health care provider acting on the covered person's behalf shall bear all costs associated with the appeal that are normally paid by the covered person." The proposed language in paragraph (c)1 states only that a member shall pay the fee and does incorporate language to address a provider's legal responsibility. The commenter requested that the Department include language in paragraph (c)1 that allows for "a member *or a provider acting on behalf of a member* shall pay . . . [.]"

One commenter supported the proposed $75.00 limit in paragraph (c)3 on annual filing fees for any one member. The commenter requested clarification as to whether this limit applies to a single patient/subscriber per year or to a health care provider who takes an assignment of benefits from his or her patients and files multiple IURO reviews on multiple patients with multiple carriers. The commenter suggested that the annual cap apply to health care providers irrespective of the number of carriers filed against or patient claims pursued. The commenter added that in practice, providers who take an assignment of benefits from their

patients file the vast majority of appeals and are the parties in interest who should benefit from the annual cap on fees while acting on behalf of their patients to get their claims paid.

RESPONSE: The Department appreciates the support for these changes. N.J.S.A. 26:2S-11.c provides that the processing fee for an external appeal be paid by the covered person or a health care provider acting on a covered person's behalf. Therefore, N.J.A.C. 11:24-8.7(c) and 11:24A-3.6(c) are being clarified upon adoption to refer to members or health care providers acting on a member's behalf. The $75.00 cap is on the filings fees paid per member, not per provider. A provider who files several external appeals on behalf of a single member is covered by the cap unlike the provider who files individual external appeals on behalf of several members.

21. COMMENT: One commenter supported the amendments to N.J.A.C. 11:24-8.7(h), which requires the IURO to refer all cases for full review to an expert physician *in the same specialty or area of practice* who would generally manage the type of treatment that is the subject of the appeal, and added that this is consistent with the 2010 amendments to the New Jersey chiropractic scope of practice statute at N.J.S.A. 45:9-14.5, which states that it is unlawful for any person, not duly licensed in this State, to practice chiropractic or to render a utilization management decision that limits, restricts or curtails a course of chiropractic care. However, according to the commenter, since the enactment of this statute it is a common practice for reviewing providers to fail to disclose their identity or state licensure in UM reviews and only have a medical director sign off on UM reviews denying chiropractic care, making it impossible to determine if reviewers are complying with the statutory mandate. The commenter stated that the same situation will most likely occur with UM reviews by IUROs under the proposed amendments, and that transparency in the process and compliance with N.J.S.A. 45:9-14.5 would be promoted by including a requirement that the same specialty

reviewer for the IURO disclose their identity and New Jersey health care provider license number on every IURO decision.

RESPONSE: The amendments to N.J.S.A. 45:9-14.5(d) state that only a New Jersey licensed chiropractor may render a utilization management decision that limits, restricts, or curtails a course of chiropractic care. The law does not require that chiropractors identify themselves on each such decision. Moreover, the Independent Health Care Appeals Program established by N.J.S.A. 26:2S-12 is permitted to use consultant non-New Jersey licensed physicians in the same specialty or area of practice as providers who would generally manage the type of treatment that is the subject of the appeal, as long as a full review is also conducted by a registered professional nurse or physician licensed to practice in New Jersey and the final recommendation is approved by the medical director of the IURO. See N.J.A.C. 11:24-8.7(g) and (h).

22. COMMENT: One commenter addressed the proposed amendments to N.J.A.C. 11:24A-3.5, Internal adverse benefit determinations appeals process. The commenter emphasized that individuals being treated at inpatient facilities must have equal access to the same appeals process. The commenter's concern stems from the proposed deletion of the existing language addressing "situations in which the covered person is confined in an inpatient facility" at N.J.A.C. 11:24A-3.5(j)1i.

RESPONSE: The Department eliminated this phrase because it added text stating that a 72-hour turnaround of a stage 1 appeal applies to cases regarding admissions, which includes all cases in which a covered person seeks care while confined in an inpatient facility.

23. COMMENT: One commenter stated that the new definition of "medical necessity" at N.J.A.C. 11:24A-3.6 must reflect the new Federal parity legislation for mental healthcare and addiction treatment services.

RESPONSE: The Federal Mental Health Parity and Addiction Equity Act of 2008 does not require any specific definition of medical necessity. Rather, it requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

24. COMMENT: One commenter stated that it supported all of the strict deadlines imposed upon carriers to promptly respond to appeals and claim disputes in the proposed amendments, but pointed out that the proposed amendments do not include any penalty provisions to ensure carrier compliance. According to the commenter, it is a common practice for carriers to fail to comply with various regulatory deadlines with no penalty or regulatory provision to deter this conduct. By way of example, the commenter stated that carriers and third party administrators routinely fail to respond to appeals pursuant to the regulatory deadlines, routinely process and respond to requests for appeal as "provider inquiries" (even though the word "appeal" is mentioned multiple times in the appeal request), reject appeal requests and send their own consent form to the patient, fail to properly address dates of service that were contained in member appeal letters which precludes the provider's ability to request IURO review for those dates of service, fail to provide a detailed clinical rationale of their decision and do not send supporting material to the provider, fail to detail in writing the next steps in the appeal process in their appeal responses, and separate appeal requests and process the notes as a "submission of notes" and not an appeal. The commenter suggested that the Department implement a penalty provision to provide a deterrent effect and ensure compliance with these regulations. The commenter added that the Department has already proposed a similar penalty provision in its PIP proposal, PRN 2011-163, which states that "An insurer that fails to respond to an internal appeal filed in accordance with (a) through (i) above

shall lose the right to raise defenses in an arbitration on the issue that was the subject of the appeal."

RESPONSE: A carrier that fails to comply with the requirements regarding external appeals is already subject to the penalties set forth at N.J.S.A. 26:2S-16 (that is, penalties of between $250.00 and $10,000 per day). Violations of the requirements regarding utilization management are subject to N.J.S.A. 17B:30-52.c, which states that if a payer fails to respond timely to an authorization request, the request is deemed approved. Moreover, if a carrier does not complete the internal appeals process timely, the member or provider may proceed directly to the external appeals process in certain circumstances. Finally, violations of these rules could be considered unfair claims settlement practices subject to the sanctions specified at N.J.S.A. 17B:30-20.

Federal Standards Statement

A Federal standards analysis is not required because the requirements contained in the adopted amendments are the same as those imposed by the Patient Protection and Affordable Care Act (Public Law 111-148, enacted on March 23, 2010) and the Health Care and Education Reconciliation Act (Public Law 111-152, enacted on March 30, 2010), collectively known as the Affordable Care Act, which reorganizes, amends and adds to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act); the Departments of Health and Human Services, Labor and the Treasury interim final regulations implementing PHS Act section 2719 at 75 FR 43330 (July 2010), regarding internal claims and appeals and external review processes for group health plans and health insurance issuers offering coverage in the group and individual markets; and by the July, 2011 amendments to the July, 2010 regulations at 76 FR 37208.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

11:24-8.4 Appeals of adverse benefit determinations

(a) – (b) (No change from proposal.)

(c) An HMO shall provide the member and/or the provider acting on behalf of the member, free of charge, with any new or additional evidence or rationale, which will be relied upon, considered or utilized, or generated by the HMO (or at the direction of the HMO) in connection with an adverse benefit determination on a pre-service or post-service claim. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the *[initial decision or the decision at the stage 1 appeal or stage 2 appeal is rendered]* ***final internal adverse benefit determination is required to be provided*** in order to give the member or provider a reasonable opportunity to respond prior to that date.

(d) – (f) (No change from proposal.)

11:24-8.6 Formal internal utilization management appeal process (Stage 2)

(a) (No change from proposal.)

(b) The formal internal utilization management appeal panel shall *[include]* ***have access to*** consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue***, or such other licensed provider as may be mutually agreed upon by the parties***. In no event, however, shall the consulting practitioner or professional have been involved in the adverse benefit determination at issue.

(c) – (f) (No change from proposal.)

11:24-8.7 External appeals process

(a) – (b) (No change from proposal.)

(c) The fee for filing an appeal shall be as follows:

1. Members ***or health care providers acting on a member's behalf*** shall pay a $25.00 filing fee, payable by check or money order to the 'New Jersey Department of Banking and Insurance." The filing fee shall be refunded to the member ***or health care provider*** if the final internal adverse benefit determination is reversed by the IURO;

2. – 3. (No change from proposal.)

(d) – (l) (No change from proposal.)

11:24A-3.5 Internal adverse benefit determinations appeals process

(a) – (e) (No change from proposal.)

(f) A carrier must provide the covered person and/or the provider acting on behalf of the covered person, free of charge, with any new or additional evidence or rationale, which will be relied upon, considered or utilized, or generated by the carrier (or at the direction of the carrier) in connection with the pre-service or post-service claim. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which *[the initial decision or the decision at the stage 1 appeal or stage 2 appeal is rendered]* ***the final internal adverse benefit determination is required to be provided*** in order to give the covered person or provider a reasonable opportunity to respond prior to that date.

(g) – (j) (No change from proposal.)

(k) Carriers shall provide in stage 2 appeals for a covered person (or the covered person's designated provider, if the covered person has consented to have a provider act in his or her behalf) to pursue his or her appeal before a panel of physicians and/or other providers selected by the carrier who have no been involved in the adverse benefit determination at issue.

1. The panel shall *[include]* ***have access to*** consultant providers who are trained or who practice in the same specialty as would typically manage the case at issue***, or such other licensed provider as may be mutually agreed upon by the parties***. The consulting provider(s) shall not have been involved in the adverse benefit determination at issue.

2. – 4. (No change from proposal.)

(l) (No change from proposal.)

11:24A-3.6 Independent health care appeals process

(a) – (b) (No change from proposal.)

(c) The fee for *[fling]* ***filing*** an IURO appeal shall be as follows:

1. Covered persons ***or health care providers acting on a covered person's behalf*** shall pay a $25.00 filing fee, payable by check or money order to the "New Jersey Department of Banking and Insurance." The filing fee shall be refunded to the covered person ***or health care provider*** if the final internal adverse benefit determination is reversed by the IURO;

2. – 3. (No change from proposal.)

(d) – (j) (No change from proposal.)