Appeal and Complaint Guide for New Jersey Consumers

New Jersey Department of Banking and Insurance

Phil Murphy
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Having health insurance is a good thing, and health insurers usually do what they're supposed to do. They authorize coverage for services that are medically necessary and appropriate, and pay claims that should be paid. But what happens when they don't? Does the consumer have a way to challenge decisions that seem unfair?

For consumers covered by **fully-insured** health plans issued in New Jersey, the answer is "Yes!" This Guide is designed to help such consumers understand the appeal processes they can use to challenge insurer decisions that seem wrong. The Guide explains how to file complaints with insurance companies*, and with the Department of Banking and Insurance (Department). In many cases the health insurer's decision will be reversed!

**As used in this Guide, "health insurer," "insurer" and "insurance company" refer to companies that are licensed as insurance companies, health maintenance organizations or health service corporations.*

Fully-Insured and Issued in New Jersey

First, how can you tell if your plan is **fully-insured** and issued in New Jersey – and thus eligible for the appeal processes described in this Guide? Start by pulling out your ID card. Some ID cards clearly state "Fully-Insured." If the card is a little more subtle, somewhere on the card you will find text that says something like "Insured by XYZ Company." If the plan is not fully-insured, the card will say something like "Self-Insured," "Self-funded" or may have text that says "Administered by XYZ company."

How can you tell if your plan was issued in New Jersey? If you live in New Jersey and bought the plan on your own it is an individual policy that would have been issued in New Jersey. If you have the plan through your employer you may need to ask the employer. Although, if the employer is based in New Jersey and all the employees work at New Jersey locations, the plan is most likely issued in New Jersey. If the employer is based in another state, and has locations in several states, including New Jersey, it is likely the policy was issued in another state.

If your plan is fully-insured and issued in New Jersey, keep reading!

UM and Administrative Denials

Denials can be **utilization management (UM)** denials or administrative denials. **UM denials** are refusals to pay a claim or to authorize a service or supply because the insurance company has determined that the service or supply is:

- ✓ not medically necessary to treat the covered person's illness or injury,
- ✓ experimental or investigational,
- ✓ cosmetic,
- ✓ dental rather than medical, or
- ✓ intended to treat an excluded pre-existing condition.

It is also a UM denial if an insurance company denies a covered person's request to obtain services from an out-of-network provider, when the person made that request because the insurance company's network does not have any providers who are qualified, accessible and available to perform the specific medically necessary service. This type of request is known as an **in-plan exception**.

An **administrative denial** is a refusal to pay a claim or authorize a service or supply based on contract provisions or other grounds not involving the exercise of medical judgment. Examples of administrative denials include denials of claims because the person was not covered on the date of service or the service or supply is explicitly excluded from coverage (e.g. adult hearing aids).

UM Denials: Internal and External Appeal

A covered person or a provider, acting with the consent of the covered person, has the right to contest a UM denial through internal and external appeals. In an **internal appeal**, tthe covered person (or the provider, with the consent of the covered person) submits a request to the insurance company to reverse a UM denial, i.e. a denial of a claim or an authorization that is based on a lack of medical necessity or the other grounds listed on page 1. The request should explain why the covered person and/or provider believe the denial was inappropriate.

An **external appeal** is a request to an independent utilization review organization (IURO) to reverse a UM denial, generally following an unsuccessful internal appeal or appeals. An IURO is an organization of medical professionals that is not part of or affiliated with an insurance company. In New Jersey, the Department of Banking and Insurance contracts with IUROs to review internal appeals and render decisions on external appeal requests submitted by persons covered by fully-insured health benefits plans issued in New Jersey.

Covered persons should state in both their internal and external appeal requests whether they want their appeal processed on an expedited basis and the reasons they believe expedited treatment is warranted.

Internal Appeal – Back to the Insurance Company

A covered person, or a provider acting with the covered person's consent, can appeal a UM denial within 180 days of receipt of the denial. Persons covered by group health benefits plans, typically through an employer, have a right to two levels of internal appeal, **Stage 1** and **Stage 2**. Persons covered by individual health benefits plans have a right to a **Stage 1** appeal.

Stage 1 A Stage 1 appeal is an informal internal review which allows the covered person and/or the provider to speak to and appeal the UM denial to the insurance company's medical director and/or the physician who rendered the UM denial. A Stage 1 appeal is to be completed by the insurance company as soon as possible in accordance with the medical exigencies of the case. A Stage 1 appeal must be concluded within 72 hours in cases involving urgent or emergency care, an admission, availability of care, continuation of a stay and situations in which the covered person received emergency services but has not been discharged from a facility. In all other cases, the insurance company must conclude the Stage 1 appeal within 10 days. If the Stage 1 decision upholds the UM denial, a person covered by an individual health benefits plan can submit a request for an external appeal. A person covered by a group health benefits plan can instead initiate a Stage 2 appeal.

Stage 2 In a Stage 2 appeal, a person covered by a group health benefits plan, or a provider acting with the covered person's consent, can file an appeal before a panel of physicians and/or other healthcare professionals selected by the carrier provided they were not involved in the UM denial being appealed. The panel shall have access to practitioners who are trained or who practice in the same specialty as the case being appealed. Stage 2 appeals must be filed within 180 days of the Stage 1 denial. The Insurance company must acknowledge receipt of the Stage 2 appeal in writing within 10 business days of receipt. Stage 2 appeals must be concluded as soon as possible in accordance with the medical exigencies of the case. However, in cases involving urgent or emergency care, an admission, availability of care, continued stay and situations where the covered person received emergency services but has not been discharged, the Stage 2 appeal must be completed in no more than 72 hours. In all other cases, the insurance company shall complete a Stage 2 appeal in no more than 20 business days.

External Appeal to the IURO

If an insurance company does not comply with the time frames for completion of a Stage 1 or Stage 2 appeal, the covered person and/or the provider generally has the right to proceed directly to an external appeal. In addition, a covered person or provider can bypass the internal appeal and proceed directly to an external appeal if the insurance company waives its right to an internal review or if the covered person or provider has simultaneously applied for an expedited internal review and an expedited external review.

A request for an external appeal must typically be filed within four months of receipt of the decision on the internal appeal. Persons covered by Medicaid have 60 days from receipt of the decision on the internal appeal to request an external appeal. The covered person or provider should electronically file the request for external appeal by providing the information requested at:

https://njihcap.maximus.com

Persons who are unable to submit a request for an external appeal electronically can download and print the appeal from the Maximus website above. Persons may also contact Maximus and ask that an appeal form be sent to them by regular mail and/or by fax. The completed appeal form may be returned to Maximus by fax or mail as set forth below.

Fax: 585-425-5296; **Mail:** Maximus Federal – NJ IHCAP, 3750 Monroe Avenue, Suite 705, Pittsford, New York 14534

Questions about the application process can be directed to Maximus Federal by calling **888-866-6205** or e-mailing **Stateappealseast@maximus.com**

The covered person or provider should include with the request for an IURO appeal:

- ✓ All information submitted to the Insurance company
- ✓ Any additional information the covered person or provider wants considered by the IURO
- ✓ The insurance company's initial UM denial
- ✓ The insurance company's decision(s) on the internal appeal(s).

The IURO will refer the case to a physician in the appropriate specialty and complete its review as soon as possible in

accordance with the medical exigencies of the case, which will not exceed 45 days. Review time is limited to 48 hours in appeals involving urgent or emergency care, an admission, availability of care, continued stay, situations in which the covered person received emergency services but has not been discharged, and cases where the standard 45 day review time would jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function.

The decision of the IURO is binding on the carrier and the covered person, except if other remedies are available under state or federal law. There is a $25 processing fee for applications accepted for review by the IURO. The fee is waived for persons who demonstrate financial hardship and for persons who are successful in their appeal. If the IURO's decision is adverse to the covered person, the IURO will bill the $25 processing fee to the covered person or provider. The IURO's decision and the records provided to it are confidential. The Department issues semi-annual reports on the IURO program which can be found at at **www.state.nj.us/dobi/division_insurance/managedcare/ihcapreports.htm**.

Administrative Denials: Complaint to the Insurance Company

Covered persons and providers may complain to the insurance company about denials based on reasons other than UM. For example, if there is a question as to whether the plan covers a certain service or supply. Insurance companies must respond to such complaints within 30 days and must advise covered persons and providers that if they are dissatisfied with the response, they may contact the Department of Banking and Insurance.

All Denials: Complaints to the Department

Covered persons may file complaints directly with the Department of Banking and Insurance. The Department investigates all types of complaints regarding coverage. Complaints can relate to one or more of the following types of issues: UM, billing, coverage denial or limitation, deductible, coinsurance or out of pocket costs not accumulating properly, issuance of identification cards or benefit books, cancellation of coverage, inability to access the insurance company through call centers and web sites, and any other aspect of coverage or service from the insurance company. Information on submission of complaints by covered persons to the Department is available at: **www.state.nj.us/dobi/consumer.htm**.

www.dobi.nj.gov

1-800-446-7467