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TWENTY-EIGHTH LEGISLATIVE REPORT
INDEPENDENT HEALTH CARE APPEALS PROGRAM
DEPARTMENT OF BANKING AND INSURANCE

This is the twenty-eighth report to the Legislature on the managed care coverage denial appeal process. This report covers the period from January 16, 2012 through July 15, 2012.

The Health Care Quality Act, enacted on August 7, 1997, and amended on January 16, 2001, gives New Jersey residents many important consumer rights. Among the most significant is the right to appeal to an independent organization for a binding determination when a carrier denies, limits or terminates a covered service on the grounds that it is not medically necessary. The right of appeal is offered through the Independent Health Care Appeals Program (IHCAP) administered by the New Jersey Department of Banking and Insurance's (Department) Office of Managed Care (OMC).

Effective February 6, 2012, the Department amended the Health Care Quality Act regulations, which govern the IHCAP, to comply with the Federal Interim Final Rules Relating to Internal Claims and Appeals Processes and External Review under the Patient Protection and Affordable Care Act. This report includes the following amended language: the time period to file an appeal was changed from 60 days to four months; if a covered person is able to demonstrate financial hardship, the filing fee is waived altogether instead of being reduced to $2.00; the external review organization must render a decision for a standard appeal within 45 calendar days from receipt of the appeal, which was changed from 30 business days after receiving all documents necessary to complete the review; and the decision rendered by the external review organization is now binding on both the carrier and the covered person, whereas before it was only binding on the carrier.

Four hundred five (405) requests for an external appeal were filed with the Department's Office of Managed Care during the time period of this report. Of the 405 requests filed, 291 met the requirements for processing and were forwarded to an independent utilization review organization (IURO) for preliminary review, where 287 appeals were accepted by the IUROs for full review. Reasons for rejection and subsequent return of the appeal to the appellant included, in order of prevalence: failure to exhaust the carrier's internal appeal process; non-eligibility of the member due to federal law preemption under ERISA; not a utilization management (UM) issue; failure to provide signed consent to appeal; appeal request not received within four months of the Stage 2 denial; out of state coverage; issue already resolved; and not a covered benefit.

Of the 287 appeals accepted by the IUROs for full review, 231 appeals have been completed and 56 are pending. Of the 231 appeals completed, the independent panel supported the carrier's decision 148 times (64%) and disagreed with the carrier's decision 83 times (36%). In the previous 6-month period, July 16, 2011 through January 15, 2012, the review panel agreed with the carrier in 67% of the cases. However, it should be noted that the overall numbers remain small, and that caution should be used in observing changes from one reporting period to the next. The most frequent categories of appeals in descending order of occurrence are: denial of inpatient hospital days; denial of home health services; denial of chiropractic services; denial based on the carrier's determination that a requested service was experimental/investigational; denial of behavioral health services (inpatient and outpatient); denial of surgical services; denial of durable medical equipment; denial of outpatient medical treatment; denial of prescription drugs; denial of outpatient rehabilitation therapy; denial of dental services; denial of requests for referrals to out of network specialists; denial of substance abuse services (inpatient and outpatient); denial of coverage for cosmetic versus medically necessary services; denial of skilled nursing care and denial of coverage for emergency services. The first category involving hospital inpatients accounted for substantially more denials than any other category.

The medical specialties affected by the 231 appeals completed during the period covered by this report are listed in descending order of occurrence in the table below:

Medical Specialty	Total Cases
Internal Medicine	40
Psychiatry	28
Pediatrics	28
Rehabilitation	20
Chiropractic	19
Cardiology	15
Neurology	12
Infectious Disease	9
OB/GYN	8
Pulmonary	7
Gastroenterology	7
Orthopedic	6
Oral/Maxillofacial	4
General Surgery	4
Oncology	4
Pain Management	4
Pediatric Endocrinology	4
Plastic Surgery	3
Vascular Surgery	2
Family Medicine	2
Urology	2
Radiology	1
Allergy/Immunology	1
Ophthalmology	1

Two tables are attached demonstrating the number of appeals filed for each carrier. Table 1 represents the number of appeals and outcomes during the period of this report.

Table 2 indicates the number of appeals and outcomes during the previous 6-month reporting period, July 16, 2011 through January 15, 2012. Carriers with no appeals have been omitted. The first column indicates the market share for each carrier. The second column provides the total number of appeals accepted for full review by the independent panel. Appeals categorized as completed are those for which the panel has communicated its determination to the carrier. Appeals that are still in the process of being reviewed by the panel are considered pending. The third column shows the independent panel's determination. If the panel determines that the carrier's determination of medical necessity was appropriate, the panel upholds the carrier's decision. However, if the panel determines that the consumer is being denied medically appropriate care, the panel disagrees with the carrier's decision and decides in favor of the consumer. If all or part of the panel's decision is in favor of the consumer, the carrier is required to promptly provide coverage for the healthcare services found by the panel to be medically necessary covered services. During the period covered by this report, all carriers exhibited compliance with determinations rendered by an IURO; therefore, no penalties or sanctions were imposed.

This report indicates a slight decrease in the number of appeals filed by consumers over the previous 6-month period (405 compared to 467). Accordingly, the number of requests that ultimately went forward to a full review decreased (287 compared to 378). The total number of appeals filed, continues to remain small considering the large number of residents enrolled in HMOs and other managed care plans in New Jersey (over 2.9 million), as reflected in the calendar year table below:

	External Appeal Requests Filed with OMC that Met Processing Requirements	External Appeals Accepted By IUROs for Full Reviews
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

How the Appeal System Works

It is important to remember that consumers are required to exhaust their carrier's internal appeals process before submitting an appeal for consideration by an independent panel. Under New Jersey law, all carriers must have an internal appeals process that meets standards set by the Department. This requirement was established to provide an incentive for carriers to resolve most disputes internally, with only unresolved issues rising to the level of the external appeals process.

During the period covered by this report, all external appeal case reviews were conducted by panels convened by the Island Peer Review Organization (IPRO) and Permedion, Inc. These panels, consisting of medical professionals, including specialty physicians appropriate to the area under review, 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 ranged from approximately $788 to $920 for this reporting period. Consumers pay a $25 filing fee for an external appeal, which is waived in cases of financial hardship. During the period of this report, there were 17 cases of financial hardship.

Consumers are given 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 external appeals panel within 45 calendar days from receiving the appeal to complete the review, but the panel can act within a matter of hours, if necessary.

Consumer Education

By New Jersey law, consumers 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 has failed to notify its member of the right to appeal, the Department has taken prompt corrective action.

Consumers are also informed about their rights, including the right to appeal, in an HMO Report Card. The fifthteenth HMO Report Card was made available to the public in the fall of 2011. Consumers can also access information regarding the external appeals process through the Department's website, www.dobi.nj.gov.

In addition to the appeals system, the OMC operates a hotline (1-888-393-1062) for consumers to register complaints about their carriers. During the period of this report, January 16, 2012 through July 15, 2012, the OMC handled 4427 telephone inquiries and complaints and 608 written complaints. These complaints involve issues such as access to care, quality of care, and denial of coverage issues.