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SEMI-ANNUAL LEGISLATIVE REPORT
INDEPENDENT HEALTH CARE APPEALS PROGRAM
DEPARTMENT OF BANKING AND INSURANCE

This is the semi-annual report to the Legislature on activities related to the Independent Health Care Appeals Program from July 16, 2014 through January 15, 2015.

The Health Care Quality Act, enacted on August 7, 1997, established the Independent Health Care Appeals Program to provide covered persons with the right to appeal to an independent utilization review organization (IURO) for reversal of a carrier's denial, limitation or termination of a covered service on the grounds that it is not medically necessary. 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. The New Jersey Department of Banking and Insurance administers the Independent Health Care Appeals Program and currently contracts with two (2) IUROs to conduct the appeal reviews.

Three hundred fifty five (355) requests for an external appeal were filed with the Department's Office of Managed Care during the time period of this report. Of the 355 requests, 224 met the requirements for processing and were accepted by the IUROs for full review. The appeals determined not to be eligible for the Independent Health Care Appeals Program were rejected for the following reasons: the person was covered by a self-funded plan; the person failed to exhaust the carrier's internal appeal process; the issue was already resolved or was not a utilization management (UM) issue; the appeal request was not received within four months of the Stage 2 denial; coverage was out of state coverage; the person failed to submit the filing fee or provide a signed consent to appeal; and the person was covered by Medicare.

The IUROs rendered decisions on 176 of the 224 appeals at the time of this report. The remaining 48 appeals are in the process of being reviewed by an IURO. Of the 176 appeals, the IURO upheld the carrier's denial 103 times (58.5%) and overturned or modified the carrier's denial 73 times (41.5%). In the previous 6-month period, July 16, 2013 through January 15, 2014, the IURO upheld the carrier's denial in 62% 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 appeals involved both inpatient and outpatient services, with denial of hospital inpatient days accounting for the highest number of appeals. A related category, reductions in acuity level, also had a relatively high number of appeals. The other categories of appeals, in descending order of number were denials of dental services; behavioral health services (inpatient and outpatient); prescription drugs; home health services; surgical services; services determined by the carrier to be experimental/ investigational; services determined by the carrier not to be a covered benefit; substance abuse services (inpatient and outpatient); outpatient rehabilitation therapy; outpatient medical treatment; skilled nursing care; durable medical equipment; adult day care; requests for referrals to out of network specialists; chiropractic services; coverage for emergency services, and services determined by the carrier to be cosmetic and not medically necessary.

The appeals involved various medical specialties as shown in descending order of occurrence in the table below:

Medical Specialty	Total Cases
Psychiatry	29
Rehabilitation	23
Internal Medicine	22
Pediatrics	15
Neurology	12
Oral/Maxillofacial	11
OB/GYN	7
Cardiology	6
Orthopedic	6
Gastroenterology	5
Oncology	5
Plastic Surgery	5
Pain Management	5
Geriatrics	4
General Surgery	4
Pediatric Endocrinology	3
Urology	2
ENT	2
Pulmonary	2
Allergy Immunology	2
Orthodontics	1
Neurosurgery	1
Family Medicine	1
Chiropractic	1
Ophthalmology	1
Infectious Disease	1

The number and disposition of appeals filed for each carrier during the past year is shown in the attached table. Table 1 reports the number of appeals and outcomes during the period of this report and Table 2 shows the same information for the previous 6-month reporting period, January 16, 2014 through July 15, 2014. The market share for each carrier is also included. Carriers with no appeals have been omitted. The table shows the IURO determinations for all 176 appeals. After review of all medical information submitted by the carrier and the covered person, the IURO determines whether the carrier's denial of services should be upheld or whether the carrier's denial of services should be overturned. The overturn of a carrier's denial signifies that the IURO believes that the services being requested for the covered person are medically necessary and appropriate, and should therefore be covered by the carrier. If all or part of the IURO's decision is in favor of the covered person, the carrier is required to promptly provide coverage for the healthcare services found by the IURO 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.

The number of appeals filed by covered persons, since the establishment of the IHCAP Program in 1997, continues to remain small considering the large number of residents enrolled in HMOs and other managed care plans in New Jersey (over 3.09 million). However, as the table below shows, there has been a continuous increase in the number of appeals filed by covered persons, with a marked upturn in appeals starting in 2011.

	External Appeal Requests Filed with OMC that Met Processing Requirements	External Appeals Accepted By IURO 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
CY 2012	672	665
CY 2013	792	521
CY 2014	695	446

How the Appeal System Works

It is important to remember that covered persons are required to exhaust the carrier's internal appeals process before submitting an appeal for review by an IURO. 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 the two IUROs under contract with the Department --Island Peer Review Organization (IPRO) and Permedion, Inc. The reviews are performed by medical professionals, including specialty physicians appropriate to the area under review. The physician reviewers 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 the fees ranged from $870 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 39 cases of financial hardship. The carrier is required to refund the $25 filing fee to the covered person if the carrier's denial is overturned.

Consumers are allowed 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 IURO within 45 calendar days from receiving the appeal request, however, the IURO can act within a matter of hours in urgent or emergency cases.

Consumer Education

New Jersey law requires that covered persons 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.

The Department recently published an Appeal and Complaint Guide for New Jersey Consumers explaining the utilization management appeal process and informing covered persons of their right to file complaints against carriers with the Department. The Guide is available on the Department's website at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf. The Department also produces an annual HMO Report Card which includes information on the appeal process. The seventeenth HMO Report Card was made available to the public last year.

In addition to administering the Independent Health Care Appeals Program, the Office of Managed Care operates a hotline (1-888-393-1062) for consumers to register complaints about their carriers. During the period of this report, 687 complaints and 147 telephone inquiries were handled. The complaints involve issues such as access to care, quality of care, and denial of coverage.