BULLETIN
OMC-2000-04

To: **All Health Maintenance Organizations (HMOs) Doing Business in New Jersey**

From: **Elisabeth P. Salberg, RN, CPHQ**
Director, Office of Managed Care

Date: **August 15, 2000**

Re: **Complaints and Appeals**

It has come to the attention of the Department of Health and Senior Services (Department) that confusion continues to exist in understanding how to process complaints (amended N.J.A.C. 8:38-3.7, formerly N.J.A.C. 8:38-3.6) and utilization management denial appeals (N.J.A.C. 8:38-8). The purpose of this Bulletin is to inform the HMOs of the Department's position regarding the areas of confusion, and therefore, clarify the process.

I. Written vs. Verbal

All complaints and requests for appeal from a member, regardless of whether they are governed by N.J.A.C. 8:38-3.7 or N.J.A.C. 8:38-8, and regardless of the stage, may be submitted to the HMO verbally or in writing. Appeal and Complaint policies and procedures should reflect this.

2. Reason for Utilization Management Denial

In the HMO's notice of denial of coverage for a covered service that is issued to the member and the provider, stating that the requested service "does not meet criteria" is an insufficient explanation of the denial decision. HMOs may use this phrase only if it is then followed by an explanation that contains clinical details pertaining to the specific denial made. The decision is to be based on the HMO's written clinical criteria and protocols that have been developed in accordance with N.J.A.C. 8:38-8.1(b).

3. Appeals

3a. Cosmetic vs. Medically Necessary

Distinguishing medically necessary covered services from services not covered due to their being cosmetic, is sometimes difficult. If the HMO determines that a service is cosmetic rather than medically necessary and therefore is not a covered service, and the member or the member's provider, acting on behalf of the member with the member's consent, disputes the HMO's decision, N.J.A.C. 8:38-8 applies to the denial, not N.J.A.C. 8:38-3.7. The appeal must be processed as a utilization management determination, subject to an HMO's 2-stage internal utilization management appeal process and subject to the external Independent Health Care Appeals Program (IHCAP) process (N.J.A.C. 8:38-8.7(e)2 and 8.7(g)) and the applicable time frames as governed by N.J.A.C. 8:38-8 and N.J.S.A. 26:2S-11. HMO denial notices to the member and provider must indicate this.

3b. Experimental-Investigational

If the HMO determines that a service is experimental or investigational and the member or provider, acting on behalf of the member with the member's consent, disputes this determination, N.J.A.C. 8:38-8 applies, not N.J.A.C. 8:38-3.7, and the appeal must be processed as a utilization management determination, subject to the external IHCAP process (N.J.A.C. 8:38-8.7(e)2 and 8.7(g)) and the applicable time frames as governed by N.J.A.C. 8:38-8 and N.J.S.A. 26:2S-11. HMO denial notices to the member and provider must indicate this.

3c. Dental vs. Medical

If the HMO determines that a service is dental rather than medical and the member or provider, acting on behalf of the member with the member's consent, disputes this determination on the basis that the service is medical and not dental, N.J.A.C. 8:38-8 applies, not N.J.A.C. 8:38-3.7. The appeal must be processed as a utilization management determination, subject to the external IHCAP process (N.J.A.C. 8:38-8.7(e)2 and 8.7(g)) and the applicable time frames as governed by N.J.A.C. 8:38-8 and N.J.S.A. 26:2S-11. HMO denial notices to the member and provider must indicate this.

3d. Pre-existing Condition

If the HMO determines that a service is denied on the basis of a pre-existing condition, N.J.A.C. 8:38-3.7 may apply and the appeal may be processed as a complaint (see number 4). Pre-existing conditions are a contractual matter. However, there are certain situations where denials made on the grounds of "pre-existing condition" may be disputed by either the member or the provider, acting on behalf of the member with the member's consent. These cases, which would involve situations where a reasonable person would not know to seek treatment due to the absence of symptoms, are subject to the appeal process as defined by N.J.A.C. 8:38-8.

3e. Provider Network Cases

Provider network issues are handled under N.J.A.C. 8:38-3.7 unless there is an issue of medical necessity that is not a matter of personal choice or convenience.

Example:

If a denial is issued for an out-of-network service because the HMO has determined that comparable services are available in-network, and the member, or the provider, acting on behalf of the member with the member's consent, argues that it is medically necessary for the member to go outside the network, N.J.A.C. 8:38-8 applies, not 8:38-3.7. HMO denial notices to the member and provider must indicate this.

4. Complaints (N.J.A.C. 8:38-3.7)

HMOs have an obligation to notify members and providers of their right to contact the following agencies if the member or provider is not satisfied with the HMO's redress of complaints regarding matters other than denial, termination or limitation of a covered service:

For complaints regarding provider networks, quality of care, access to medical care, HMO or provider service delivery or the health care delivery system generally, the HMO's final determination notice should direct the party who filed the complaint to the following agency:

Department of Health and Senior Services
Office of Managed Care
P.O. Box 360
Trenton, NJ 08625-0360
(888) 393-1062

For complaints regarding an HMO's business practice, financial solvency, premium issues, member enrollment matters or termination of coverage, the HMO's final determination notice should direct the party who filed the complaint to the following agency:

Department of Banking and Insurance
Division of Enforcement and Consumer Protection
P.O. Box 329
Trenton, NJ 08625-329
(609) 292-5316

For complaints made by Medicaid recipients, the HMO's final notice must inform the member of the right to contact to the following agency:

Department of Human Services
Office of Managed Care
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712
1 (800) 356-1561

For complaints made by Medicare recipients, please do not refer the member to DHSS or DOBI, rather, please inform the member of their right in matters concerning quality of medical care or possible premature hospital discharge, to contact:

The Peer Review Organization of New Jersey
1(800) 624-4557

or for all other matters, to contact:

The Health Care Financing Administration (HCFA)
26 Federal Plaza
New York, New York 10278
(212) 264-3657

5. UM Appeals - Self Funded Plans

The Department has received a number of requests for external appeals from members who are in employer sponsored self-funded plans subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) and exempt from state law. This is to remind you that the Department of Health and Senior Services has no jurisdiction over self-funded plans, and consequently, members whose health care is provided through self-funded plans currently do not have access to the IHCAP, facilitated by the Department. For utilization management denial appeals where the member is covered by a self-funded plan and the member or the provider is dissatisfied with the outcome of the internal appeal process, please remember that the member and/or provider should be directed to the member's employer or to the:

United States Department of Labor
Pension and Welfare Benefits Administration
U.S. Customs House
6 World Trade Center
New York, New York 10048
1 (212) 637-0600

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