BULLETIN
OMC 2002-01

TO: **Insurers offering Health Benefits Plans, Health Service Corporations, Medical Service Corporations, Hospital Service Corporations and Health Maintenance Organizations Doing Business In New Jersey**

FROM: **Marilyn Dahl, Senior Assistant Commissioner, New Jersey State Department of Health and Senior Services**

DATE: **June 20, 2002**

RE: **Utilization Management Appeal Process -- Stage 1**

This bulletin is being provided to insurers, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations (collectively, "carriers") delivering or issuing for delivery health benefits plans in New Jersey, as that term is defined at N.J.S.A. 26:2S-1 et seq.[1] to provide guidance for complying with certain state and federal laws regarding utilization management appeals.

The United States Department of Labor published final rules (29 C.F.R. 2560) on November 21, 2001 regarding, among other things, claims procedures,[2] which had an effective date of January 1, 2001. Subsequently, the rules at 29 C.F.R. 2560.503-1 (hereinafter, generally referred to as "federal rules") were amended to delay their effective date with respect to claims filed under a group health plan.[3] In accordance with the amendment, the rules at 29 C.F.R. 2560.503-1 apply to claims filed under a group health plan (as defined by the rules) on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003. The original effective date applies in all other circumstances (see, 29 C.F.R. 2560.503-1(o)).

The federal rules include standards for making and disseminating benefits determinations as well as standards for the appeal of adverse benefits determinations. These standards overlap with state rules at N.J.A.C. 8:38-8 and 8:38A-3.5 and 4.12 (hereinafter, generally referred to as "state rules") regarding the similar subject matter,

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[1] The term "health benefits plan" means a benefits plan that pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in New Jersey by or through a carrier, and includes (but is not limited to) Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by law. The term does not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection issued pursuant to N.J.S.A. 39:6A-1 et seq., or hospital confinement indemnity coverage.

[2] See, 65 FR 70245.

[3] See, 66 FR 35885, July 9, 2001.

although the federal rules apply to a broader category of determinations and appeals in some respects. The federal rules define an "adverse benefit determination" to mean

> "…a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit…including, with respect to group health plans, a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate."

These federal rules do not generally preempt the state rules. However, the federal rules do require preemption of state law that regulates insurance if such laws prevent the application of the federal rules (see, 29 C.F.R. 2560.503-1(k)). Arguably, the requirement that carriers comply with certain provisions of the state rules would prevent the carriers from also complying with the federal rules, and thus, those provisions are preempted. Specifically, the federal rules require that, upon appeal, no deference be afforded to an initial adverse benefits determination, and that the review be conducted by someone (in a fiduciary capacity) who is neither the original reviewer, nor a subordinate of the original reviewer who rendered the initial adverse benefits determination (see, 29 C.F.R. 2560.503-1(h)). Currently, state law, at N.J.A.C. 8:38-8.5 and 8:38A-3.5 essentially requires that Stage 1 utilization management appeal reviews are to be conducted by the same physician who made the initial adverse utilization management decision. *Accordingly, carriers cannot be required to comply with same-reviewer requirement of the state rules for Stage 1 appeals with respect to their group health plans. However, carriers shall assure that the Stage 1 reviewer otherwise is a physician.*

The federal rules do not apply to non-group health plans. However, the Department does not believe it is expeditious for carriers to operate a dual system for their Stage 1 reviews, and suspects that doing so will lead to confusion for both the carriers and the Department when appeals are presented at Stage 3 (the Independent Health Care Appeals Program). Thus, the Department will be pursuing a rule change in the future to conform its requirement concerning the Stage 1 reviewer to the federal rules. In the interim, as of July 1, 2002, the Department will elect to enforce the reviewer requirement for health benefits plans such that the Stage 1 reviewer, who otherwise meets the requirements of the state law, no longer has to be the same reviewer who made the initial adverse utilization management decision.