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FIFTEENTH LEGISLATIVE REPORT
INDEPENDENT HEALTH CARE APPEALS PROGRAM
DEPARTMENT OF BANKING AND INSURANCE

This is the fifteenth report to the Legislature on the managed care coverage denial appeal process. This report covers the period from July 16, 2005 through January 15, 2006.

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), which is now administered by the New Jersey Department of Banking and Insurance (Department) since the transfer of the Office of Managed Care from the New Jersey Department of Health and Senior Services to the Department. The transfer complies with an order signed on June 30, 2005 by former Acting Governor Richard J. Codey. The order went into effect August 29, 2005. The transfer was completed by October 31, 2005.

Two hundred and forty (240) requests for an external appeal were filed with the Office of Managed Care during the time period of this report. Of the 240 requests filed, 168 met the requirements for processing and were forwarded to an independent utilization review organization (IURO) for preliminary review, where 163 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: non-eligibility of the member due to federal law preemption under ERISA; not a utilization management (UM) issue; out of state coverage; failure to exhaust the carrier's internal appeal process; request not received within 60 days of the Stage 2 denial; issue already resolved.

Of the 163 appeals accepted by the IUROs for full review, 129 appeals have been completed and 34 are pending. Of the 129 appeals completed, the independent panel supported the carrier's decision 87 times (67 %) and disagreed with the carrier's decision 42 times (33 %). In the previous 6 month period, January 16, 2005 through July 15, 2005, the review panel agreed with the carrier in 56 % of 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 level of care for hospital inpatients; denial of outpatient rehabilitation therapy; denial of dental services; denial of chiropractic services; denial of surgical

procedures; denial of durable medical equipment; denial of outpatient medical treatment and diagnostic testing; denial based on the carrier's determination that the requested service was experimental or investigational; denial of coverage for prescription drugs; denial of home health services; denial based on cosmetic procedure versus medical necessity; denial of substance abuse services (inpatient and outpatient); denial of coverage for emergency services; and denial of coverage based on the requested service not being a covered benefit. The first two categories involving hospital inpatients accounted for substantially more than all the other categories combined.

The medical specialties affected by the 129 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	17
Psychiatry	13
Pediatrics	11
Neurology	10
General Surgery	9
Oncology	8
Cardiology	7
Pulmonary	6
Chiropractic	6
Pediatric Endocrinology	5
Infectious Disease	5
Dental	4
Orthopedic	4
Plastic Surgery	4
Vascular Surgery	4
Rehabilitation	2
OB/GYN	2
Neurosurgery	1
Radiology	1
Reconstructive Surgery	1
Speech Pathology	1
Urology	1
Oral Maxillofacial	1
Orthodontics	1
Neonatology	1
Otolaryngology	1
Gastroenterology	1
Family Practice	1
Pediatric Pulmonology	1

Two tables are attached demonstrating the number of appeals filed for each carrier. The first table indicates the number of appeals and outcomes from March 1997, when the HMO regulations went into effect, through January 15, 2006.

The second table represents the number of appeals and outcomes during the period of this report, July 16, 2005 through January 15, 2006. Carriers with no appeals have been omitted. The first column indicates the market share for each carrier's HMO business only. The market share for non-HMO business is not recorded by the Department of Banking and Insurance, and thus not shown. 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 shall promptly provide coverage for the health care 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 virtually the same number of appeals filed by consumers over the previous 6 month period (241 compared to 240). The number of requests that ultimately went forward to a full review decreased (179 compared to 163). The total number of appeals filed, however, continues to remain small considering the large number of residents (over 2.9 million) enrolled in HMOs and other managed care plans in New Jersey, 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

How the Appeal System Works

It is important to remember that consumers are required to exhaust their carrier's internal appeal process before submitting an appeal for consideration by an independent panel. Under New Jersey law, all carriers must have an internal appeal 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 appeal process.

During the period covered by this report, all external appeal case reviews were conducted by panels convened by the HealthCare Quality Strategies, formerly the Peer Review Organization of New Jersey (PRONJ), the Island Peer Review Organization (IPRO) and the Peer Review Systems, Inc. d/b/a Permedion. 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 $595 to $916 per case for this reporting period. Consumers pay a $25 filing fee for an external appeal, which can be reduced to $2 in cases of financial hardship. During the period of this report, there were only four appellants who requested the reduced fee and all met the requirements for financial hardship status.

Consumers are given up to 60 days 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 30 business days after receiving all documents necessary 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 most recent (ninth) Report Card was made available to the public in the Fall of 2005. Consumers can access it through their workplace or in mailings from the Department.

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, July 16, 2005 through January 15, 2006, the OMC handled 1,103 telephone inquiries and complaints and 448 written complaints. These complaints involve issues such as access to care, quality of care, and denial of coverage issues.