State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
CONSUMER PROTECTION SERVICES
OFFICE OF MANAGED CARE
PO BOX 329
TRENTON, NJ 08625-0329

TEL (609) 777-9470
FAX (609) 633-0807

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

RICHARD J. BADOLATO
Acting Commissioner

PETER L. HARTT
Director

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 (IHCAP) from January 16, 2015 through July 15, 2015.

The Health Care Quality Act established the IHCAP 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 IHCAP and currently contracts with two (2) IUROs to conduct the appeal reviews.

Four hundred forty (440) external appeals were filed with the Department's Office of Managed Care (OMC) during the time period of this report. Of the 440 appeals, 266 met the requirements for processing and were accepted and reviewed by the IUROs. The appeals determined not to be eligible were rejected for the following reasons: failure to exhaust the carrier's internal appeal process; issue already resolved; non-eligibility because the member is covered by self-funded plan or by Medicare; not a utilization management (UM) issue; failure to provide signed consent to appeal; out of state coverage; appeal request not received within four months of the Stage 2 denial; and the appeal involves a non-covered benefit.

The IUROs rendered decisions on 266 appeals during this period. Of the 266 appeals, the IURO upheld the carrier's denial 139 times (52.3%) and overturned or modified the carrier's denial 127 times (47.7%). In the previous 6-month period, July 16, 2014 through January 15, 2015, the IURO rendered decisions on 176 appeals. The carrier's denial was upheld in 58.5% of the cases. However, it should be noted that the overall numbers remain small, and caution should be used in observing changes from one reporting period to the next.

The table below shows a breakdown of the 266 appeals by category. The highest number of appeals were for denials of home health care. These denials involved the reduction of private duty nursing services by Medicaid HMOs. Hospitals filed appeals for denials of inpatient admissions, reductions of acuity level, and denial of hospital days. These appeals, collectively, accounted for 78, or 29.3%, of the 266 appeals. The categories of behavioral health and substance abuse accounted for 38 appeals and involved the denial of treatment in a residential facility. The other categories of appeals, in descending order were denials of a covered medication, outpatient rehabilitation therapy, outpatient medical treatment/diagnostic testing, skilled nursing facility, services determined by the carrier to be experimental/ investigational; services determined by the carrier not to be a covered benefit; durable medical equipment; denial of a surgical procedure; requests for referrals to out of network specialists; services determined by the carrier to be dental, other, and services determined by carrier to be cosmetic.

Independent Health Care Appeals Program
January 16, 2015 – July 15, 2015

IURO Categories of Appeal	
Categories	**Total**
Denial of home health care	32
Denial of inpatient admission	30
Denial of inpatient behavioral health treatment	28
Reduction of acuity level (inpatient)	27
Denial of a covered medication	26
Denial of inpatient hospital days	21
Denial of outpatient rehabilitation therapy (PT, OT, Speech, Cardiac, etc.)	19
Denial of outpatient medical treatment/diagnostic testing	16
Denial of skilled nursing facility	13
Service considered experimental/investigational	13
Denial of inpatient substance abuse treatment	10
Service not a covered benefit	8
Denial of medical equipment (DME) and or supplies	6
Denial of surgical procedure	6
Denial of out of network specialist	4
Service considered dental, not medically necessary	4
Other	2
Service considered cosmetic, not medically necessary	1
	266

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

Medical Specialty	Total Cases
Psychiatry	43
Internal Medicine	40
Pediatrics	27
Rehabilitation	22
Cardiology	13
Gastroenterology	13
Neurology	13
Dental	11
Endocrinology	8
General Surgery	7
Infectious Disease	7
OB/GYN	7
Pulmonary	7
Oral/Maxillofacial	4
Orthopedics	4
Pediatric Endocrinology	4
Hematology Oncology	3
Oncology	3
Pain Management	3
Pediatric Pulmonary	3
Rheumatology	3
Urology	3
Anesthesiology	2
Family Medicine	2
Ophthalmology	2
Otolaryngology	2
Radiation Oncology	2
Reproductive Endocrinology	2
Chiropractic	1
Dermatology	1
Geriatrics	1
Nephrology	1
Plastic Surgery	1
Speech Pathology	1

The number and disposition of appeals filed for each carrier during this period is shown in the table below. The table does not include those carriers that had only one appeal during the six month period. The IURO determines, after review of all medical information submitted by the carrier and the covered person, 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 believed the services being requested for the covered person were 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.

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			IURO Determination			
Carrier	**Market Share***	**Total Appeals Completed**	**Disagree With Plan**	**% Disagree With Plan**	**Agree With Plan**	**% Agree With Plan**
Aetna Health	9.6%	14	7	50.0	7	50.0
AmeriChoice **		60	30	50.0	30	50.0
Amerigroup	6.6%	37	18	48.6	19	51.4
AmeriHealth	5.8%	17	8	47.1	9	52.9
Cigna	1.3%	6	1	16.7	5	83.3
Horizon	51.0%	98	46	46.9	52	53.1
Oxford**		15	8	53.3	7	46.7
United**		15	6	40.0	9	60.0
Total		262*	124		138	

* The table does not include four (4) carriers that had only one appeal each during this six month period.

** AmeriChoice (now d/b/a United Healthcare Community Plan), Oxford and United are all owned by UnitedHealth Group. The combined market share is 21.8.0%.

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 3.19 million). However, as the table on the next page 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. The table shows the number of appeals received by the Office of Managed Care (OMC) that were determined to meet the criteria for acceptance by the IURO. These appeals are then forwarded to the IURO. The table also shows the number of appeals accepted by the IURO. This number is often less than the

number accepted by OMC because of the carriers' decision to cover the service before the IURO initiates its review.

	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	548	521
CY 2014	454	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, except in urgent or emergency cases. 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 $900 to $920 for this reporting period. Consumers pay a $25 filing fee for an external appeal, which is waived in 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.

An Appeal and Complaint Guide for New Jersey Consumers is available on the Department's website at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf. This Guide explains the utilization management appeal process and provides instructions for filing complaints against carriers with the Department. 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, 483 complaints, Inquiries (cases referred to other jurisdiction) 414 and 863 telephone inquiries were handled. The complaints involve issues such as access to care, quality of care, and denial of coverage.