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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 January 16, 2017 through July 15, 2017.

The Health Care Quality Act established the Independent Health Care Appeals Program to provide covered persons with the right to appeal to an independent utilization review organization (IURO) a carrier's denial, limitation or termination of a covered service on the grounds that it is not medically necessary. The overturn of a carrier's denial signifies that the IURO determined, after a review of all medical information submitted by the carrier and the covered person, that the services 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. The IURO's decision 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 (Department) administers the Independent Health Care Appeals Program and currently contracts with two IUROs to conduct the appeal reviews.

Seven hundred ninety (790) external appeals were filed with the Department's Office of Managed Care during the time period of this report. Of the 790 appeals, 546 were accepted for review by the IUROs. Appeals determined to be ineligible for the Independent Health Care Appeals Program were rejected for the following reasons: failure to exhaust the carrier's internal appeal process; not a utilization management (UM) issue; member is covered by self-funded plan; fair hearing request; failure to provide signed consent to appeal; issue already resolved; out of state coverage; appeal untimely; and the appeal involves a non-covered benefit.

The IUROs rendered decisions on 546 appeals during this period. Of the 546 appeals, the IURO upheld the carrier's denial 219 times (40.1%) and overturned or modified the carrier's denial 327 times (59.9%). In the previous 6-month period, July 16, 2016 through January 15, 2017, the IURO rendered decisions on 605 appeals. The carrier's denial was upheld in 44.6% of the cases and overturned or modified in 55.4% of the cases.

The appeals involved various types of medical service denials as shown below:

January 16, 2017 – July 15, 2017

Category	Total
Covered medication	185
Hospital admissions, days or reduction in acuity	177
Skilled nursing facility	37
Home health care	25
Outpatient medical treatment/diagnostic testing	24
Residential behavioral health treatment	21
Dental – coverage under Medicaid contract	16
Service considered experimental/investigational	15
Surgical procedure	13
Outpatient rehabilitation therapy (PT, OT, Speech, Cardiac, etc.)	12
In-network exception	10
Other	11
TOTAL	546

The medical specialties that are most frequently represented in the appeals are as follows:

Medical Specialty	Total Cases
Gastroenterology	132
Pediatrics – primary and specialty care	58
Internal Medicine	48
Infectious Disease	41
Rehabilitation	36
Surgery	32
Psychiatry	27
OB/GYN, Neonatology	23
Cardiology	22
Neurology	19
Pulmonary	18
Oncology, Hematology, Radiation Oncology	18
Dental	16

The number and disposition of appeals filed for each carrier is shown on the table below.

January 16, 2017 – July 15, 2017

			IURO Determination			
Carrier	**Market Share***	**Total Appeals Completed**	**Disagree With Plan**	**% Disagree With Plan**	**Agree With Plan**	**% Agree With Plan**
Aetna Health	8.4%	20	13	65.0	7	35.0
AmeriChoice **		118	75	63.6	43	36.4
Amerigroup	6.2%	61	39	63.9	22	36.1
AmeriHealth	5.7%	26	12	46.2	14	53.8
Cigna	1.2%	3	1	33.3	2	66.7
Horizon	53.7%	290	173	59.7	117	40.3
Oxford**		14	8	57.1	6	42.9
United**		5	2	40.0	3	60.0
Health Republic	0.0%	3	1	33.3	2	66.7
Nippon	0.3%	2	1	50.0	1	50.0
WellCare	2.0%	4	2	50.0	2	50.0
Total		546	327		219	

** AmeriChoice (now d/b/a United Healthcare Community Plan), Oxford and United are all owned by UnitedHealth Group. The combined market share is 20.9%.

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.

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 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, and for Medicaid enrollees. 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 and up to sixty days for Medicaid enrollees 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 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.