

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Health Maintenance Organizations

Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations and Medical Service Corporations

Proposed Amendments: N.J.A.C. 11:24-1.2, 3.7 and 8.3 through 8.8 and 11:24A-1.2, 3.2, 3.4, 3.5, 3.6 and 3.7

Proposed Repeal: N.J.A.C. 11:24-8.9

Authorized By: Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-54, 26:2J-21 and 26:2S-1 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2011-210.

Submit comments by November 18, 2011 to:

Robert J. Melillo, Chief

Legislative and Regulatory Affairs

New Jersey Department of Banking and Insurance

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

Fax: (609) 292-0896

Email: legsregs@dobi.state.nj.us

The agency proposal follows:

Summary

The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010 (collectively known as the "Affordable Care Act" or "ACA"). The Affordable Care Act reorganizes, amends and adds to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. On July 23, 2010, the United States Departments of Health and Human Services (HHS), Labor and the Treasury collectively (the Departments) issued interim final regulations implementing PHS Act section 2719 at 75 FR 43330 (July 2010 regulations), <http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=24056>, regarding internal claims and appeals and external review processes for group health plans and health insurance issuers offering coverage in the group and individual markets. The requirements of PHS Act section 2719 and the July 2010 regulations do not apply to

grandfathered health plans as that term is defined in section 1251 of the Affordable Care Act. On June 24, 2011, the Departments issued amendments to the July 2010 regulations at 76 FR 37208 (July 2011 amendments),

<http://www.gpo.gov/fdsys/pkg/FR-2011-06-24/pdf/2011-15890.pdf>.

The July 2010 regulations and the July 2011 amendments include the following:

Internal Claims and Appeals:

The July 2010 regulations set forth separate rules for group health coverage and individual health coverage. Regarding group health plans, the July 2010 regulations contain a broader definition of an "adverse benefit determination" than the existing Federal Department of Labor (DOL) claims procedure regulation in that the new definition includes a rescission of coverage. The July 2010 regulations definition includes a denial, reduction or termination of, or a failure to provide or make a payment that is based on a determination of an individual's eligibility to participate in a plan or health insurance coverage; a determination that a benefit is not a covered benefit; the imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational or not medically necessary or appropriate.

The July 2010 regulations provide that a plan or issuer must notify a claimant of a benefit determination with respect to a claim involving urgent care as soon as possible, but not later than 24 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered under the plan or health insurance coverage. The July 2011 amendments

permit plans and issuers to follow the original 72-hour timeframe in the DOL claims procedure regulation, provided that the plan or issuer defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care."

The July 2010 regulations provide additional criteria to ensure that a claimant receives a full and fair review. In addition to complying with the requirements of the existing DOL claims procedure regulation, the plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Also, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. The July 2011 amendments eliminate the requirement to automatically provide the diagnosis and treatment codes as part of a notice of adverse benefit determination or final internal adverse benefit determination and instead substitute a requirement that the plan or issuer must provide notification of the opportunity to request the diagnosis and treatment codes (and their meanings) in all notices of adverse benefit determination (and notices of final internal adverse benefit

determination), and a requirement to provide this information upon request. The amendment also clarifies that a plan or issuer shall not consider a request for such diagnosis and treatment information to be a request for an internal appeal or external review.

The July 2010 regulations provide that claimants were permitted to immediately seek review if a plan or issuer failed to "strictly adhere" to all of the July 2010 requirements for internal claims and appeals processes. The regulations also clarified that the reviewing tribunal should resolve the dispute *de novo*. The July 2011 amendments provide an exception to the strict compliance standard for errors that are minor and meet certain other specified conditions, such as when the violation was: (1) *de minimis*; (2) non-prejudicial; (3) attributable to good cause or matters beyond the plan's or issuer's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of noncompliance. The claimant also would be entitled, upon written request, to an explanation of the plan's or issuer's basis for asserting that it meets this standard. Finally, if an external reviewer or court rejects the claimant's request for immediate review on the basis that the plan met this standard, the amendments would give the claimant the right to resubmit and pursue the internal appeal of the claim.

In addition to the above, the July 2010 regulations require a plan to provide continued coverage pending the outcome of an internal appeal, and prohibit a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review. Also, individuals in urgent care

situations and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process, under either a state external review process or the Federal external review process.

To address certain relevant differences in the group and individual markets, the July 2010 regulations require health insurance issuers offering individual health insurance coverage to comply with three additional requirements: (1) the regulations expand the scope of the group health coverage internal claims and appeals process to cover initial eligibility determinations for individual health insurance coverage. This protection is important because eligibility determinations in the individual market are frequently based on the health status of the applicant, including preexisting conditions. Applicants in the individual market should have the opportunity for a review of a denial of eligibility of coverage to determine whether the issuer is complying with the new provisions in making the determination; (2) the regulations require that health insurance issuers offering individual health insurance coverage have only one level of internal appeals. This allows the claimant to seek either external review or judicial review immediately after an adverse benefit determination is upheld in the first level of the internal appeals process; and (3) the regulations require health insurance issuers offering individual health insurance coverage to maintain records of all claims and notices associated with their internal claims and appeals processes for at least six years, and to make such records available for examination upon request.

External Review:

The July 2010 regulations provide that plans and issuers must comply with either a state external review process or the Federal external review process, and provide a basis for determining when plans and issuers must comply with each. The state external review process must: (1) provide for the external review of adverse benefit determinations (and final internal adverse benefit determinations) that are based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; (2) require issuers to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination; (3) make exhaustion of an internal claims and appeals process unnecessary if the issuer has waived the exhaustion requirement, the claimant has exhausted (or is considered to have exhausted) the internal claims and appeals process under applicable law or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal; (4) provide that the issuer against which a request for external review is filed must pay the cost of an independent review organization (IRO) for conducting the external review. If the state pays this cost, the Departments would treat the state process as meeting this requirement; this alternative is just as protective to the consumer because the cost of the review is not imposed on the consumer. However, the state process may require a nominal filing fee from the claimant requesting an external review not to exceed \$25.00, and this fee must be refunded to the claimant if the adverse benefit determination is reversed through external review or waived if payment of the fee would impose an undue financial hardship. Moreover, the annual limit on filing fees for any claimant within a single year must not exceed \$75.00;

(5) not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review; (6) allow at least four months after the receipt of a notice of an adverse benefit determination for a request for an external review to be filed; (7) provide that an IRO will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process by a state or independent entity, and in no event selected by the issuer, plan or individual; (8) provide for maintenance of a list of approved IROs qualified to conduct the review based on the nature of the health care service that is the subject of the review. Approved IROs must be accredited by a nationally recognized private accrediting organization; (9) provide that any approved IRO has no conflicts of interest that will influence its independence; (10) allow the claimant to submit to the IRO in writing additional information that the IRO must consider when conducting the external review and require that the claimant is notified of such right to do so. The process must also require that any additional information submitted by the claimant must be forwarded to the issuer within one business day of receipt by the IRO; (11) provide that the IRO's decision is binding on the plan or issuer and the claimant except to the extent that other remedies are available under state or Federal law. The July 2011 amendments clarify the language regarding the minimum requirements for state and Federal external review process standards. Specifically, these provisions are amended to add language stating that, for purposes of the binding provision, the plan or issuer must provide benefits (including payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek

judicial review of the external review decision and unless there is a judicial decision otherwise; (12) provide that, for standard external review, within no more than 45 days after the receipt of the request for external review by the IRO, the IRO must provide written notice to the issuer and the claimant of its decision to uphold or reverse the adverse benefit determination; (13) provide for an expedited external review in certain circumstances and, in such cases, the state process must provide notice of the decision as expeditiously as possible, but not later than 72 hours after the receipt of the request; (14) require that issuers include a description of the external review process in the summary plan description, policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to claimants; (15) require that IROs maintain written records and make them available upon request to the state; and (16) follow procedures for external review of adverse benefit determinations involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

HHS determines whether a state external review process meets the above requirements, and whether issuers and plans are subject to the state external review process rather than the Federal external review process. If a state external review process does not provide the minimum consumer protections of the NAIC Uniform Model Act, health insurance issuers in the state must implement the Federal external review process. The Departments have the discretion to consider an external review process in place on the date of enactment of the ACA to be in compliance with the external review requirements under PHS Act section 2719(b) "as determined

appropriate." The July 2010 regulations provided a transition period for plan years (in the individual market, policy years) beginning before July 1, 2011, in order to allow states time to amend their laws to meet or go beyond the minimum consumer protections of the NAIC Uniform Model Act. In the July 2011 amendments, the Departments modified the transition period so that the last day of the transition period is December 31, 2011, to give states that are making substantial progress in implementing state external review processes, the requisite time to complete that process.

These proposed amendments are intended to bring the Department's Health Maintenance Organization (HMO) rules at N.J.A.C. 11:24 and Health Care Quality Act (HCQA) rules at N.J.A.C. 11:24A addressing internal claims and appeals and external reviews into compliance with the July 2010 regulations and July 2011 amendments, so as to allow for the State external review process to continue to apply after January 1, 2012.

The Department's proposed amendments to the HMO rules at N.J.A.C. 11:24 and the Health Care Quality Act rules at N.J.A.C. 11:24A include the following:

N.J.A.C. 11:24-1.2 contains new definitions of "adverse benefit determination," "final internal adverse benefit determination," "pre-service claim," "post-service claim" and "urgent care claim." The existing definition of "claim" is proposed for amendment. The existing definition of "claim" as "a request for payment of charges for services rendered or supplies provided by a provider to a member" is amended to mean "a request by a member, a participating health care provider, or a nonparticipating health

care provider who has received an assignment of benefits from the member, for payment relating to health care services or supplies covered under a health benefits plan issued by an HMO."

N.J.A.C. 11:24-3.7, Complaint and appeal system, is amended to include adverse benefit determinations among the types of complaints for which an HMO must maintain a complaint and appeal system. Paragraph (a)4 is amended to require the response time for complaints to be either the current 30 days from receipt of the complaint by the HMO or, if applicable, the time frames set forth at N.J.A.C. 11:24-8, relating to independent utilization review organizations (IUROs). These amendments further revise the provisions addressing the HMO's appeals system by replacing the term "utilization management determinations" with "adverse benefit determinations," which includes utilization management determinations, and sets forth the adverse benefit determination exceptions for which appeals are not permitted.

N.J.A.C. 11:24-8.3, Utilization management determinations, is amended by adding a new paragraph (c)1, requiring an HMO to notify a provider and/or member of: a determination on an urgent care claim within 72 hours after receipt of the claim; a determination regarding a non-urgent pre-service claim (prior authorization) no later than 15 days after receipt of the claim; and of a determination on post-service claims no later than 30 days after receipt of the claim. Subsection (d) is amended by changing language that prohibits an HMO from "retroactively denying reimbursement for a covered service provided to a member" to prohibiting an HMO from "reversing a utilization management decision" where a provider has relied on the written or oral

authorization of the HMO. Subsection (e) is amended to require an HMO to provide written notice of any determination to deny coverage or authorization for services within two business days of the determination.

N.J.A.C. 11:24-8.4, Appeals of utilization management determinations, is amended by replacing the term "utilization management determinations" with "adverse benefit determinations." The amendments also provide members and/or providers 180 days to appeal such determinations. The existing rule text indicating that a member or provider may appeal in accordance with the provisions of N.J.A.C. 11:24-8.5 through 8.7 is being amended to remove N.J.A.C. 11:24-8.7. Also, for HMO members covered by group health benefits plans, the current two-stage internal review and an external IURO review process are maintained. For HMO members covered by individual health benefits plans, the proposed amendments require a one-stage internal review and an external IURO review. New subsection (c) requires an HMO to provide a member and/or provider, free of charge, with any new or additional evidence or rationale used by the HMO in connection with the denial of a pre-service or post-service claim. This information must be provided as soon as possible and sufficiently in advance of the date on which an initial decision, a stage 1 appeal decision or a stage 2 appeal decision is rendered in order to give the member or provider a reasonable opportunity to respond prior to that date. New subsection (d) permits an appeal of an urgent care claim to be submitted orally or in writing. New subsection (e) requires all adverse benefit determinations to be culturally and linguistically appropriate pursuant to 45 CFR 147.236(e) and to include certain information set forth in the rule. New subsection (f)

requires an HMO to provide continued coverage of an ongoing course of treatment pending the outcome of a stage 1 or stage 2 internal appeal or an external appeal.

N.J.A.C. 11:24-8.5, Informal internal utilization management appeal process (Stage 1), is amended to replace the term "utilization management determination" with "adverse benefit determination" throughout, and to set forth the adverse benefit determination exceptions for which appeals are not permitted. In addition to the current requirement that all stage 1 appeal determinations regarding urgent or emergency care be concluded within 72 hours, including all situations in which the member is confined as an inpatient, the proposed amendments delete the language addressing situations in which the member is confined as an inpatient and require that same timeframe to apply to determinations regarding an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility. Also, the current five business days requirement for all other appeals is extended to 10 calendar days. These additional days will enable HMOs to comply with the new requirement at N.J.A.C. 11:24-8.4(c) to provide members with any new or additional evidence or rationale that will be used by the HMO in connection with an adverse benefit determination or a pre-service or post-service claim sufficiently in advance of the date on which the initial decision or decision on appeal is rendered, so the member has a reasonable opportunity to respond prior to that date.

N.J.A.C. 11:24-8.6, Formal internal utilization management appeal process (Stage 2), is amended to reflect the new Federal requirement that an HMO maintain a

stage 2 internal appeal process only for members covered by a group health benefits plan or their providers. The term "utilization management determination" is replaced with "adverse benefit determination" throughout the section. Currently, subsection (b) requires the HMO's formal internal utilization management appeal panel to have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties, and permits the member and/or provider to request that the consulting practitioner or professional participate in the panel's review of the case. The amendments require the panel to "include" such consultant practitioners, and eliminate the option that the parties may agree to the availability of another licensed health care professional and the member's and/or provider's ability to request that the consulting practitioner or professional participate on the panel. Subsection (d) states that all stage 2 appeal determinations regarding urgent or emergency care be concluded within 72 hours, including all situations in which the member is confined as an inpatient, the amendments delete the language addressing situations in which the member is confined as an inpatient and apply the same timeframe to determinations regarding an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility. The proposed amendments delete the current language at subsection (e), permitting an HMO to extend its review for up to an additional 20 business days if certain conditions are met. New subsection (f) sets forth the circumstances under which a member and/or provider is relieved of his or her

obligation to complete the HMO's internal review process and may proceed directly to the external appeals process. Existing subsection (g) is recodified as paragraphs (f)1, 2 and 3 and amended to permit a member and/or provider to proceed directly to the external appeals process if the HMO fails to comply with any of the deadlines for completion of the internal adverse benefit determination appeals set forth in N.J.A.C. 11:24-8.5 or 8.6 unless the HMO's violation does not cause, and is not likely to cause, prejudice or harm to the member and/or provider, so long as the HMO demonstrates that the violation was for good cause or due to matters beyond the control of the HMO and that the violation occurred in the context of an ongoing, good faith exchange of information between the HMO and the member and/or provider, and is not reflective of a pattern or practice of non-compliance by the HMO. Also, the member and/or provider may request a written explanation of the violation from the HMO, which the HMO is required to provide within 10 days. Further, if an external reviewer or a court rejects the member's and/or provider's request for immediate review, the member and/or provider has the right to resubmit and pursue the internal appeal of the claim and the HMO within 10 days must provide the member and/or provider with notice of the opportunity to resubmit and pursue the internal appeal. In such a case, the time period for refiling the claim shall begin to run upon the member's and/or provider's receipt of such notice. The existing language permitting a member and/or provider to proceed directly to the external appeals process if the HMO for any reason expressly waives its rights to an internal review of any appeal is codified as paragraph (f)2. New paragraph (f)3 is added and permits a member and/or provider to proceed directly to the external

appeals process if he or she has applied for expedited external review at the same time as applying for an expedited internal appeal. Existing language at subsection (g) pertaining to the external appeals process set forth at N.J.A.C. 11:24-8.7 is proposed for deletion.

N.J.A.C. 11:24-8.7, External appeals process, currently permits any HMO member and/or provider who is dissatisfied with the results of the internal appeal process to pursue an appeal to an IURO, but the right to an external appeal is contingent upon the member's first fully complying with both stages of the internal appeal process. The proposed amendments permit any HMO member and/or provider to appeal a final internal adverse benefit determination to an IURO except in cases where the adverse benefit determination was based on a determination of group or member ineligibility, including rescission, or on application of a contract exclusion or limitation not relating to medical necessity. The proposed amendments further require the HMO to provide a member and/or provider with a minimum four-month period, rather than 60 days, from receipt of the final internal adverse benefit determination to request an IURO appeal and also update the mailing address for the request and provide a phone number. The proposed amendments also revise the language at subsection (c) regarding fees for filing an IURO appeal. Members will continue to pay a \$25.00 filing fee, but that fee must be refunded to the member if the final internal adverse benefit determination is reversed by the IURO. Further, the fee is waived upon a determination of financial hardship as demonstrated by certain evidence as set forth in the rule. Finally, the annual filing fees for any one member may not exceed \$75.00.

Subsection (e) is amended to state that an IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that the member has fully complied with the internal appeal process unless the member was relieved of the obligation to complete the HMO internal review process because of the reasons set forth at new N.J.A.C. 11:24-8.6(f) (discussed above).

Subsection (f) currently requires the IURO, after completing its preliminary review of an appeal, to immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefor. The proposed amendments additionally require the IURO to notify the member of his or her right to submit in writing, within five business days of the member's receipt of the notice of acceptance of his or her appeal, any additional information to be considered in the IURO's review. The IURO is further required to provide the HMO with any such additional information within one business day of receipt of the information. The term "utilization management determination" at subsection (g) is changed to "final internal adverse benefit determination" and changes the scope of the IURO's review from determining whether the member was deprived of medically necessary covered services to determining whether the member was deprived of coverage of medically necessary covered services. The existing requirement at subsection (h), that the IURO's review initially be conducted by a registered professional nurse or physician licensed to practice in New Jersey, and referred to a consultant physician, when necessary, in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal, is

replaced with the requirement that the IURO refer all cases for full review to an expert physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. This subsection is further amended to require the medical director of the IURO, who approves all final decisions, to be a physician licensed to practice in New Jersey.

Subsection (i) is proposed for amendment to change the timeframe within which the IURO must issue its decision from the existing 30 business days from receipt of all documentation necessary to complete the review to 45 days from receipt of the request for IURO review. The proposed amendment also eliminates any extensions of time for an IURO to render its determination. The existing requirement, at paragraph (i)1, that an IURO complete its review no later than 48 hours following its receipt of urgent or emergency care appeals is expanded to include appeals involving an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involving a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function. The amendments to this paragraph further require that if the IURO does not provide a written determination within that 48-hour timeframe, the IURO must provide a written determination within 48 hours of providing the verbal determination.

Existing subsection (j) requires that if an IURO determines that a member was deprived of "medically necessary covered services," it must "recommend" to the

member and/or provider, the HMO and the Department the appropriate covered health care services the member should receive. The amended subsection replaces those terms with "coverage of medically necessary covered services" and "advise."

New language is proposed at subsection (k) requiring that an IURO's determination be binding on the HMO and the member and/or provider except to the extent that other remedies are available to either party under State or Federal law, and that an HMO provide benefits (including payment on the claim) pursuant to the IURO's determination without delay regardless of whether the HMO intends to seek judicial review of the decision and unless there is a judicial decision stating otherwise.

The existing language at subsection (k) requiring an HMO to submit a written report to the IURO, member and/or provider and the Department within 10 business days of receipt of the IURO's determination of an appeal is maintained. New language is added indicating that the HMO must specify its intentions sooner if the medical exigencies of the case warrant a more rapid response. The report, however, will only need to indicate how the HMO will implement the IURO's determination because the HMO no longer may decide whether it will accept and implement or reject the IURO's recommendations in whole or in part.

N.J.A.C. 11:24-8.8, General requirements for independent utilization review organizations, is amended to add a new requirement that an IURO must be accredited by a nationally recognized private accrediting organization.

N.J.A.C. 11:24-8.9, Department review of HMO actions on IURO recommendations, is proposed for repeal, as the rule is no longer necessary because of

new N.J.A.C. 11:24-8.7(k) requiring an IURO's determination to be binding on the HMO and member.

N.J.A.C. 11:24A-1.2 contains new definitions of "adverse benefit determination," "claim," "final internal adverse benefit determination," "post-service claim," "pre-service claim" and "urgent care claim."

N.J.A.C. 11:24A-3.2, pertaining to utilization management disclosure requirements, is amended to replace references to "utilization management decisions" with "adverse benefit determinations" or "final adverse benefit determinations," and sets forth exceptions to those determinations under which appeals are not permitted. Paragraph (b)3 is proposed for amendment to require that a carrier's disclosure statements to a covered person regarding their right to appeal a final adverse benefit determination must also include a statement that the covered person shall have a minimum four-month period to file the application for review of such determinations.

N.J.A.C. 11:24A-3.4, Utilization management program, is amended by adding new paragraph (d)3 requiring a carrier to notify a provider and/or covered person of a determination on an urgent care claim within 72 hours after receipt of the claim, of a determination regarding a non-urgent pre-service (prior authorization) no later than 15 days after receipt of the claim, and of a determination on a post-service claim no later than 30 days after receipt of the claim. Subsection (e) is proposed for amendment by changing language that prohibits a carrier from "retroactively denying reimbursement for a covered service provided to a covered person" to prohibiting a carrier from "reversing a utilization management decision" where a provider has relied on the

written or oral authorization of the carrier. Subsection (f) is amended to require a carrier to provide written notice of any determination to deny coverage or authorization for utilization management services within two business days of the determination, rather than a maximum of five days.

N.J.A.C. 11:24A-3.5, Internal utilization management appeals process, is proposed for amendment to change the heading to Internal adverse benefit determinations appeals process, and references in the section to utilization management decisions are changed to adverse benefit determinations. The amendments proposed at subsection (a) set forth the exceptions to those adverse benefit determinations under which appeals are not permitted. This subsection is also amended to permit a covered person to appeal an adverse benefit determination within 180 days of receipt of the adverse benefit determination. Both subsections (b) and (c) are proposed for amendment to delete "upon request" as it is no longer necessary. Subsection (e) is amended to require carriers to establish a two-stage internal appeal process for covered persons in group health benefits plans and a one-stage internal appeal process for covered persons in individual health benefits plans. Proposed new subsection (f) requires a carrier to provide a covered person and/or provider, free of charge, with any new or additional evidence or rationale used by the carrier in connection with a pre-service or post-service claim. This information must be provided as soon as possible and sufficiently in advance of the date on which an initial decision, a stage 1 appeal decision or a stage 2 appeal decision is rendered in order to give the covered person or provider a reasonable opportunity to respond prior to that date.

New subsection (g) permits an appeal of an urgent care claim to be submitted orally or in writing. New subsection (h) requires all adverse benefit determinations to be culturally and linguistically appropriate pursuant to 45 CFR 147.136(e) and to include certain information set forth in the rule. New subsection (i) requires a carrier to provide continued coverage of an ongoing course of treatment pending the outcome of a stage 1 or stage 2 internal appeal or an external appeal.

Recodified subsection (j) is proposed for amendment to expand the applicability of the 72-hour timeframe within which stage 1 appeals from a determination regarding urgent or emergency care, including all situations in which the covered person is confined in an inpatient facility, must be concluded to include determinations regarding an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility. The existing language addressing situations in which the covered person is confined in an inpatient facility is proposed for deletion. The amendments also propose to extend the current five business days requirement for concluding all other appeals to 10 calendar days, so that carriers will be able to comply with the new requirement at subsection (f) described above. The proposed amendments to paragraph (j)2 add a requirement that at the conclusion of stage 1, the carrier must provide a written explanation of the covered person's right to file a stage 2 appeal for persons covered by a group health benefits plan or to file an appeal with an IURO for persons covered by an individual health benefits plan, including applicable time limits and other information for doing so. The proposed amendments to recodified subsection (k) require the appeal panel of

physicians and/or other providers selected by the carrier to include consultant providers who are trained or who practice in the same specialty as would typically manage the case at issue or other licensed providers, and eliminates the current requirement that the panel only have access to such consultant providers or such other licensed providers as may be mutually agreed upon by the parties. Existing subparagraph (k)1ii, which requires the carrier to allow a consulting provider(s) to participate with the panel if so requested by the covered person or the covered person's provider, is proposed for deletion as no longer necessary. The amendments proposed at paragraph (k)3 expand the applicability 72-hour timeframe within which stage 2 appeals from a determination regarding urgent or emergency care must be concluded, including all situations in which the covered person is confined in an inpatient facility, to include determinations regarding an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility. The language addressing all situations in which the covered person is confined in an inpatient facility is proposed for deletion. The amendments delete any extension of the carrier's review period at paragraph (k)4. The amendments also delete paragraph (k)6, that stated that a carrier must not provide a stage 2 appeal until a covered person's right to a stage 1 appeal is exhausted. New subsection (l) sets forth the circumstances under which a covered person and/or provider is relieved of his or her obligation to complete the carrier's internal review process and may proceed directly to the external appeals process.

N.J.A.C. 11:24A-3.6, Independent health care appeals process, is amended to permit any covered person and/or provider to appeal a final internal adverse benefit determination to an IURO, except in cases where the adverse benefit determination was based on a determination of eligibility, including rescission, or on application of a contract exclusion or limitation not relating to medical necessity. It should be noted that persons with dental coverage issued by dental plan organizations (DPOs) and dental service corporations (DSCs) are not permitted to seek an independent appeal through an IURO because the Health Care Quality Act at N.J.S.A. 26:2S-1 et seq. does not apply to DPOs or DSCs. The amendments delete the existing requirement, and exceptions thereto, at paragraph (a)1 that a covered person and/or provider exhaust all appeal rights he or she may have under the policy or contract with the carrier before pursuing an appeal to an IURO. The amendments also delete paragraphs (a)2 and 3 because they are no longer necessary given the deletion of the exhaustion of all appeal rights requirement. Subsection (b) is amended to provide a minimum four-month period from the date of receipt of the carrier's final internal adverse benefit determination for appealing through an IURO. The existing language at subsection (b) requiring an appeal to be made within 60 days from the date of receipt of the carrier's final benefit determination, or the last date of filing of an appeal by the covered person or provider believes the carrier has failed to meet required time frames, is proposed for deletion. Also proposed for deletion is the existing language at subsection (b) and at paragraphs (b)1 and 2 requiring that the appeal be made by application to the Department on a form accessible on the Department's website and that fees specified

at subsection (c) be submitted with the application because the amendments also require the covered person and/or provider to file a written request with the Department for an IURO appeal on forms provided by the carrier, which must include a general release executed by the covered person for all medical records pertinent to the appeal. Subsection (c) is proposed for deletion and replaced with a new subsection pertaining to fees for filing an IURO appeal. Covered persons will continue to pay a \$25.00 filing fee, but that fee must be refunded to the covered person if the final internal adverse benefit determination is reversed by the IURO. The fee is waived upon a determination of financial hardship as demonstrated by certain evidence set forth in the rule. Finally, the annual filing fees for any one covered person may not exceed \$75.00. Subsections (d) and (e) are merged and amended to require an IURO to conduct a preliminary review upon receipt of a request for an appeal if it determines that the covered person has met certain conditions set forth in the rule. Existing paragraph (e)3 is deleted, as unnecessary because of the elimination of the requirement to fully comply with a carrier's internal appeals process before seeking an IURO appeal.

Recodified subsection (e) requires the IURO, after completing its preliminary review of an appeal, to immediately notify the member (which is proposed for amendment to "covered person") and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefor. The proposed amendments additionally require the IURO to notify the covered person of his or her right to submit in writing, within five business days of the covered person's

receipt of the notice of acceptance of his or her appeal, any additional information to be considered in the IURO's review. The IURO is further required to provide the carrier with any such additional information within one business day of receipt of the information. At recodified subsection (f), as a result of the carrier's "decision" is replaced with as a result of the carrier's "final internal adverse benefit determination." The existing requirement at recodified subsection (g), that the IURO's review initially be conducted by a registered professional nurse or physician licensed to practice in New Jersey, and referred to a consultant physician, when necessary, in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal, is replaced with the requirement that the IURO refer all cases for full review to an expert physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. This subsection is further amended to require the medical director of the IURO, who approves all final decisions, to be a physician licensed to practice in New Jersey. Recodified subsection (h) is amended to require an IURO to complete its review and issue its written decision within 45 days of its receipt of the request for IURO review, rather than the current 30 business days requirement, and to eliminate any extensions of time for an IURO to render its determination. The existing requirement at recodified subsection (i) that an IURO complete its review within 48 hours following its receipt of an urgent or emergency appeal is expanded to include appeals related to an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility or involves a

medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function. Also, if that determination made within 48 hours was verbal, the IURO must provide a written determination no later than 48 hours after providing the non-written determination. Recodified subsection (j) requires an IURO to include in its written decision whether it determined that a covered person was deprived of receipt of or benefits for medically necessary services otherwise covered under his or her contract or policy, and if so, to specify the services the covered person should receive or receive benefits therefor. This language has been amended to state that the IURO's written decision must state whether it determined if the covered person was deprived of coverage of medically necessary services, and if so, must specify the appropriate covered services the person should receive. New paragraph (j)2 is added requiring the IURO's determination to be binding on the carrier and the covered person, except to the extent that other remedies are available to either party under State or Federal law and that the carrier must provide benefits (including payment on the claim) pursuant to the IURO's determination without delay regardless of whether the carrier intends to seek judicial review of the decision, unless there is a judicial decision stating otherwise.

At N.J.A.C. 11:24A-3.7, Carrier action on the IURO decisions, the Department is maintaining the requirements that the carrier provide a written report to the covered person and his or her provider (if the provider assisted in filing the appeal), the Department and the IURO within 10 business days of the date that the carrier first

receives the decision of the IURO describing how the carrier will implement the IURO's decision and sooner if the medical exigencies of the case warrant a more rapid response. However, subsection (b) is proposed for deletion.

A 60-day comment period is provided for this notice of proposal, and therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the notice is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed amendments provide additional protections for consumers regarding their health plans' internal claims and appeals and external review processes in that they will reduce the incidence of excessive delays and inappropriate denials and enhance consumers' confidence in and satisfaction with their health plan. Among the amendments relating to internal and external appeals of claims that will be favorable to consumers are the broadened scope of the types of complaints that may be appealed; the 72-hour notice requirement for urgent-care claims; the requirement that a plan must provide a claimant, free of charge, any new or additional evidence considered or generated by the plan and any new rationale in connection with the claim; the prohibition on plans' extending their review time on an internal appeal if certain conditions are met; the right of consumers to be provided notices in a culturally and linguistically appropriate manner; the right for consumers enrolled in individual plans to appeal denied claims to a nationally accredited independent utilization review organization (IURO) if an internal appeal is denied; expedited access to external review in some cases (including emergency situations or cases where the plan did not follow

the rules in the internal appeal, with certain exceptions); the requirement that consumers be charged only a nominal fee for filing an external appeal and that the fee be returned to them if they prevail on appeal; the broadened scope of an IURO review from determining whether consumers were deprived of medically necessary covered services to whether they were deprived of coverage of medically necessary covered services; the requirement that IURO decisions are binding on the consumer and the health plan except to the extent that other remedies are available under State or Federal law; and the requirement that a plan must provide benefits (including payment on a claim) without delay if a consumer wins the IURO review whether or not the plan is seeking judicial review, unless a judicial decision states otherwise.

The proposed amendments are also favorable to health plans in that they will improve the extent to which they provide benefits to consumers enrolled in their plans, thereby fostering their enrollees' confidence in their fairness. Additionally, the establishment of more uniform requirements and consumer protections will reduce the complexity of claims and appeals processing requirements, thereby increasing efficiency. The amendments will also be favorable to health plans in that they may ease certain administrative burdens. The amendments are providing health plans with additional time to conclude appeals, other than urgent or emergency care appeals, in order to comply with the new requirement that they provide members and covered persons with additional information used in deciding an appeal sufficiently in advance of the date of the decision so that the member or covered person may respond to the information before the decision date. The amendments permit consumers to appeal an

urgent-care claim orally or in writing and to by-pass a stage 2 internal appeal in some circumstances. The amendments will also eliminate some of the most abusive practices regarding enrollees' claims decisions and appeals in which some plans may have engaged. However, the amendments may be unfavorable to health plans to the extent that plans will be required to tighten some timeframes for making claims decisions and to provide additional information to enrollees who are appealing those decisions.

IUROs may also be somewhat unfavorably impacted by the proposed amendments. They will be required to broaden the scope of their review and comply with tighter timeframes for issuing decisions. IUROs must also have external review accreditation from a nationally recognized accreditation organization, such as URAC all reviews must be conducted by an expert physician in the specialty/area of treatment that is the subject of an appeal and the medical director who approves all final decisions must be a State-licensed physician.

Economic Impact

Health plans may experience an immediate unfavorable impact in complying with the proposed amendments in that they may need to revise processes, create or revise forms, modify systems or train personnel to comply with the amendments. Health plans will be required to comply with some tighter timeframes for providing certain notices to enrollees (for example, the 72-hour timeframe for urgent-care and other determinations) and will be required to provide some additional or enhanced information to enrollees (for example, new or additional evidence or rationales used for

claim determinations and culturally and linguistically appropriate notices). These requirements may subject health plans to some modest additional costs. Health plans will also be required to bear the costs associated with an independent external appeal process conducted by an IURO, including all required notices to be provided by the IURO. In cases where the enrollee prevails, the health plan will incur the additional costs in the payment of benefits. However, these are costs that should previously have been paid to the enrollee but were initially denied by the health plan.

Notwithstanding these costs, the more uniform standards for handling health benefit claims and appeals will reduce the incidence of excessive delays and inappropriate denials, averting serious, avoidable lapses in health care quality and resultant injuries and losses to consumers. They will also enhance enrollees' level of confidence in, and satisfaction with, their health benefits and improve the plans' awareness of consumer and provider concerns, prompting plan responses that improve health care quality. Accordingly, the benefits of compliance with these proposed amendments justify any costs incurred by health benefits plans.

Finally, all of the proposed amendments that may generate these additional costs to insurers are necessary in order to conform the rules to the controlling Federal laws and regulations. Were the Department not to adopt these amendments, the insurers would, nevertheless, be compelled to comply with these Federal requirements.

Federal Standards Statement

A Federal standards analysis is not required because the requirements contained in the proposed amendments are the same as those imposed by the Patient Protection

and Affordable Care Act (Public Law 111-148, enacted on March 23, 2010) and the Health Care and Education Reconciliation Act (Public Law 111-152, enacted on March 30, 2010), collectively known as the Affordable Care Act, which reorganizes, amends and adds to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act); the Departments of Health and Human Services, Labor and the Treasury interim final regulations implementing PHS Act section 2719 at 75 FR 43330 (July 2010), regarding internal claims and appeals and external review processes for group health plans and health insurance issuers offering coverage in the group and individual markets; and July 2011 amendments to the July 2010 regulations at 76 FR 37208.

Jobs Impact

The Department does not believe that the proposed amendments will cause any jobs to be generated or lost. The Department invites interested parties to submit any data or studies concerning the jobs impact of the amendments, together with their written comments on other aspects of the proposed amendments.

Agriculture Industry Impact

The Department does not expect the proposed amendments to have any impact upon the State agriculture industry.

Regulatory Flexibility Analysis

The proposed amendments are intended to conform New Jersey's HMO and HCQA rules to the new Federal law and regulations regarding health benefits plans' internal claims and appeals and external review processes. Compliance with these amendments will impose certain reporting and/or recordkeeping requirements on health

plans and independent utilization review organizations (IUROs), some of whom may be "small businesses" as that term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Accordingly, the Department is providing a regulatory flexibility analysis.

The reporting and recordkeeping requirements of the proposed amendments are more fully described in the Summary above. While some of the proposed amendments may cause some small businesses to incur some additional costs, others may have minimal or no impact. While the additional costs a small business might incur cannot be quantified, it is unlikely that it will be necessary for the small business to engage additional professional services in order to comply with the amendments. Moreover, as explained in the Summary and Economic Impact above, the proposed amendments are required by Federal law. For this reason, the Department cannot differentiate in any standards applicable to small businesses affected by the amendments, and the proposed amendments must apply to all such entities regardless of size.

Smart Growth Impact

The proposed amendments will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact Analysis

The proposed amendments will not have an impact on housing affordability because the proposed amendments address compliance with new Federal law regarding health benefits plans' internal claims and appeals and external review processes.

Smart Growth Development Impact Analysis

The Department believes that there is an extreme unlikelihood that these amendments would evoke a change in the housing production in Planning Areas 1 and 2, or within the designated centers, under the State Development and Redevelopment Plan in New Jersey because the proposed amendments address compliance with new Federal law regarding health benefits plans' internal claims and appeals and external review processes.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

CHAPTER 24

HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER 1. SCOPE AND DEFINITIONS

11:24-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise[.]:

“Adverse benefit determination” means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or

service for which benefits are otherwise provided because the HMO determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO has rescinded the coverage.

...

"Claim[s]" means a request [for payment of charges for services rendered or supplies provided by a provider to a member] by a member, a participating health care provider or a nonparticipating health care provider who has received an assignment of benefits from the member, for payment relating to health care services or supplies covered under a health benefits plan issued by an HMO.

...

"Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by an HMO at the completion of the internal appeal process, an adverse benefit determination with respect to which the HMO has waived its right to an internal review of the appeal, an adverse benefit determination for which the HMO did not comply with the requirements of N.J.A.C. 11:24-8.4 or 8.5, and an adverse benefit determination for which the member or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

...

"Post-service claim" means any claim for a benefit that is not a "pre-service claim."

"Pre-service claim" means any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

...

"Urgent care claim" means any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or that, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

...

SUBCHAPTER 3. GENERAL REQUIREMENTS

11:24-3.7 Complaint and appeal system

(a) Every HMO shall establish and maintain a system to provide for the presentation and resolution of complaints brought by members or by providers acting on behalf of a member and with the member's consent, regarding any aspect of the

HMO's health care services, including, but not limited to, complaints regarding quality of care, choice and accessibility of providers, [and] network adequacy **and adverse benefit determinations**. All such general complaint systems must, at a minimum, incorporate to the satisfaction of the Commissioner, the following components:

1 - 3. (No change.)

4. Establishment of a specified response time for complaints, not to exceed 30 days from receipt thereof by the HMO **or, if applicable, the time frames specified in N.J.A.C. 11:24-8;**

5 - 8. (No change.)

(b) (No change.)

(c) In addition to the [complaint] process delineated **in (a)** above, every HMO shall establish and maintain a system for the presentation and resolution of appeals brought by members or by providers acting on behalf of a member and with the member's consent, with respect to [the denial, termination or other limitation of covered health care services, hereinafter referred to as utilization management] **adverse benefit** determinations[. The appeals process for utilization management determinations], **except where the adverse benefit determination was based on a determination of group or member ineligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity, which system** shall comply with all of the provisions of N.J.A.C. 11:24-8.4 through 8.7.

(d) A description of the systems for filing complaints and for appealing [utilization management] **adverse benefit** determinations shall be included in the evidence of coverage and member handbook issued to members.

(e) (No change.)

SUBCHAPTER 8. UTILIZATION MANAGEMENT

11:24-8.3 Utilization management determinations

(a) – (b) (No change.)

(c) All determinations shall be made on a timely basis, as required by the exigencies of the situation.

1. An HMO shall notify a provider and/or member of a determination concerning:

i. An urgent care claim and determination by the attending provider as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim by the HMO;

ii. A non-urgent pre-service (that is, prior authorization) no later than 15 days after receipt of the pre-service claim by the HMO; and

iii. A determination concerning a post-service claim no later than 30 days after receipt of the post-service claim by the HMO.

(d) An HMO shall not [retroactively deny reimbursement for a covered service provided to a member by a] **reverse a utilization management decision where the provider [who] relied upon the written or oral authorization of the HMO or its**

agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

(e) A member or provider acting on behalf of a member shall receive [upon request a] written notice of any determination to deny coverage or authorization for services required in this subchapter or in the evidence of coverage, which shall be subject to appeal in accordance with N.J.A.C. 11:24-8.5, 8.6 and 8.7, **within two business days of the determination**. The written notice of determination shall include an explanation of the appeal process.

11:24-8.4 Appeals of [utilization management] **adverse benefit** determinations

(a) All HMO members, and any provider acting on behalf of a member with the member's consent, may appeal any [utilization management] **adverse benefit** determination resulting in a denial, termination[,] or other limitation of covered health care services in accordance with the provisions of N.J.A.C. 11:24-8.5 [through 8.7] **and 8.6 within 180 days of receipt of the adverse benefit determination**. All members and providers shall be provided with a written explanation of the appeal process in the member handbook and upon the conclusion of each stage in the process as described in N.J.A.C. 11:24-8.5 through 8.7. [The]

1. For HMO members covered by group health benefits plans, the appeal process shall consist of an informal internal review by the HMO (stage 1 appeal), a formal internal review by the HMO (stage 2 appeal), and a formal external review (stage 3 appeal) by an independent utilization review organization (IURO) through the

Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11, as further described at N.J.A.C. 11:24A-5.

2. For HMO members covered by individual health benefits plans, the appeal process shall consist of an informal internal review by the HMO (stage 1 appeal) and a formal external review (stage 3 appeal) by an independent utilization review organization (IURO) through the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11, as further described at N.J.A.C. 11:24-8.7.

(b) (No change.)

(c) **An HMO shall provide the member and/or the provider acting on behalf of the member, free of charge, with any new or additional evidence or rationale, which will be relied upon, considered or utilized, or generated by the HMO (or at the direction of the HMO) in connection with an adverse benefit determination on a pre-service or post-service claim. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the initial decision or the decision at the stage 1 appeal or stage 2 appeal is rendered in order to give the member or provider a reasonable opportunity to respond prior to that date.**

(d) **An appeal concerning an urgent care claim may be submitted orally or in writing.**

(e) **The initial adverse benefit determination, as well as an adverse benefit determination following a stage 1 or stage 2 appeal shall be culturally**

and linguistically appropriate pursuant to 45 CFR 147.136(e) and shall include:

1. Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal;

2. The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by the HMO in the denial; and

3. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b).

(f) An HMO shall provide continued coverage of an ongoing course of treatment pending the outcome of a stage 1 internal appeal, a stage 2 internal appeal and an external appeal.

11:24-8.5 Informal internal utilization management appeal process (Stage 1)

Each HMO shall establish and maintain an informal internal appeal process (stage 1 appeal) whereby any member, or any provider acting on behalf of a member, with the member's consent, who is dissatisfied with any HMO [utilization management] **adverse benefit** determination, **except where the adverse benefit determination was based on a determination of member or group ineligibility, including rescission, or the application of a contract exclusion or limitation not relating to medical necessity**, shall have the opportunity to speak to and appeal that determination with the HMO medical director and/or physician designee who rendered the determination. All such stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergency care [(including all situations in which the member is confined as an inpatient)], **an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility** and [five business] **10 calendar** days in the case of all other appeals. If the appeal is not resolved to the satisfaction of the member at this level, the HMO shall provide the member and/or the provider with a written explanation of his or her right to proceed to a stage 2 appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

11:24-8.6 Formal internal utilization management appeal process (Stage 2)

(a) Each HMO shall establish and maintain a formal internal appeal process (stage 2 appeal) whereby any member **covered by a group health benefits plan** or any provider acting on behalf of a member **covered by a group health benefits plan** with the member's consent, who is dissatisfied with the results of the stage 1 appeal, shall have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the HMO who have not been involved in the [utilization management] **adverse benefit** determination at issue.

(b) The formal internal utilization management appeal panel shall [have available] **include** consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue [or such other licensed health care professional as may be mutually agreed upon by the parties]. In no event, however, shall the consulting practitioner or professional have been involved in the [utilization management] **adverse benefit** determination at issue. [The consulting practitioner or professional shall participate in the panel's review of the case, if requested by the member and/or provider.]

(c) (No change.)

(d) All such stage 2 appeals shall be concluded as soon as possible after receipt by the HMO in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care [(including all situations in which the member is confined as an inpatient) and, except as set forth in (e) below], **an admission, availability of care, continued stay and health care services for which the claimant received**

emergency services but has not been discharged from a facility, and which in no event shall exceed 20 business days in the case of all other appeals.

[(e) The HMO may extend the review for up to an additional 20 business days where it can demonstrate reasonable cause for the delay beyond its control and where it provides a written progress report and explanation for the delay to the satisfaction of the Department, with notice to the member and/or provider within the original 20 business day review period.]

[(f)] **(e)** (No change in text.)

(f) A member and/or provider shall be relieved of his or her obligation to complete the HMO internal review process and may, at his or her option, proceed directly to the external appeals process set forth at N.J.A.C. 11:24-8.7 if:

[(g)] **1.** [In the event that the] **The** HMO fails to comply with any of the deadlines for completion of the internal [utilization management] **adverse benefit** determination appeals set forth in N.J.A.C. 11:24-8.5 or 8.6, [or in the event that the] **unless the HMO's violation does not cause, and is not likely to cause, prejudice or harm to the member and/or provider, so long as the HMO demonstrates that the violation was for good cause or due to matters beyond the control of the HMO and that the violation occurred in the context of an ongoing, good faith exchange of information between the HMO and the member and/or provider, and is not reflective of a pattern or practice of non-compliance by the HMO.**

i. The member and/or provider may request a written explanation of the violation from the HMO and the HMO shall provide such explanation of the violation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

ii. If an external reviewer or a court rejects the member's and/or provider's request for immediate review on the basis that the HMO met the standards for the exception set forth in this paragraph, the member and/or provider has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review, not to exceed 10 days, the HMO shall provide the member and/or provider with notice of the opportunity to resubmit and pursue the internal appeal. The time period for refiling the claim shall begin to run upon the member's and/or provider's receipt of such notice;

2. The HMO for any reason expressly waives its rights to an internal review of any appeal[, then the member and/or provider shall be relieved of his or her obligation to complete the HMO internal review process and may, at his or her option, proceed directly to the external appeals process set forth at N.J.A.C. 11:24-8.7.]; or

3. The member and/or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

11:24-8.7 External appeals process

(a) Any HMO member, and any provider acting on behalf of a member, with the member's consent, [who is dissatisfied with the results of the internal appeal process set forth at N.J.A.C. 11:24-8.5 through 8.6 above, shall have the right to pursue his or her] **may appeal a final internal adverse benefit determination, except where the adverse benefit determination was based on a determination of group or member ineligibility, including rescission, or the application of a contract exclusion or limitation not relating to medical necessity,** to an independent utilization review organization (IURO) in accordance with the procedures set forth below [(stage 3 appeal). Except as set forth in N.J.A.C. 11:24-8.6(g), the right to an external appeal under this section shall be contingent upon the member's full compliance with both stages of the HMO internal appeal process set forth at N.J.A.C. 11:24-8.5 and 8.6].

(b) [To initiate an external appeal, a] **A member and/or provider shall**[, within 60 days] **have a minimum of a four-month period** from receipt of the [written determination of the stage 2 internal appeal panel under N.J.A.C. 11:24-8.6(f),] **final internal adverse benefit determination to** file a written request with the Department **for an IURO appeal**. The request shall be filed on the forms automatically provided to the member in accordance with N.J.A.C. 11:24-8.6[(f)]**(e)**, and shall include both the fee specified in (c) below and a general release executed by the member for all medical records pertinent to the appeal. The request shall be mailed to the following address:

Department of Banking and Insurance

Consumer Protection Services

Office of Managed Care

PO Box [325] **329**

Trenton, New Jersey 08625-[0325]**0329**

(888) 393-1062

(c) The fee for filing an appeal shall be **as follows**:

1. Members shall pay a \$25.00 filing fee, payable by check or money order to the "New Jersey Department of Banking and Insurance." **The filing fee shall be refunded to the member if the final internal adverse benefit determination is reversed by the IURO;**

2. Upon a determination of financial hardship, the fee [may be reduced to \$2.00] **shall be waived**. Financial hardship may be demonstrated by the member through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ [KidCare] **FamilyCare**, General Assistance, SSI[,.] or New Jersey Unemployment Assistance[.]; **and**

3. Annual filing fees for any one member shall not exceed \$75.00.

(d) Upon receipt of the appeal, together with the executed release [and the appropriate fee], the Department shall immediately assign the appeal to an IURO in accordance with N.J.A.C. 11:24-8.8, for review.

(e) Upon receipt of the request for appeal from the Department, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

1. - 2. (No change.)

3. Except as set forth at N.J.A.C. 11:24-8.6[(g)]**(f)**, the member has fully complied with [both the stage 1 and stage 2 appeals] **the internal appeal process** available pursuant to N.J.A.C. 11:24-8.5 and, **if applicable**, 8.6; and

4. The member has provided all information required by the IURO and **the** Department to make the preliminary determination, including the appeal form and a copy of any information provided by the HMO regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the HMO and any other relevant health care provider.

(f) Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefor. **The IURO shall additionally notify the member and/or provider of his or her right to submit in writing, within five business days of the member's or provider's receipt of the notice of acceptance of his or her appeal, any additional information to**

be considered in the IURO's review. The IURO shall provide the HMO with any such additional information within one business day of receipt of the information.

(g) Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the HMO's [utilization management] **final internal adverse benefit** determination, the member was deprived of **coverage of** medically necessary covered services. In reaching this determination the IURO shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the HMO pursuant to N.J.A.C. 11:24-8.1(b).

(h) [The full review referenced in (g) above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the] **The IURO shall refer all [cases] appeals for full review, as referenced in (g) above, to [a consultant] an expert** physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final [recommendations] **decisions** of the IURO shall be approved by the medical director of the IURO, **who shall be a physician licensed to practice in New Jersey.**

(i) The IURO shall complete its review and issue its [recommended] decision as soon as possible in accordance with the medical exigencies of the case which, except as

provided for in this subsection, in no event shall exceed [30 business] **45** days from receipt of [all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control, except that in no event shall it render its determination later than 90 days following receipt of a completed application. In the event the IURO needs to extend its review period, it shall, prior to the conclusion of the 30 business day review, provide written notice to the member and/or provider, to the Department, and to the HMO setting forth the status of its review and the specific reasons for the delay] **the request for IURO review.**

1. Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, **an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function**, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal. **If the IURO's determination of the appeal provided within no more than 48 hours was not in writing, the IURO shall provide written confirmation of its determination within 48 hours of providing the verbal determination.**

(j) If the IURO determines that the member was deprived of **coverage of** medically necessary covered services, the IURO shall [recommend to] **advise** the

member and/or provider who filed the appeal, the HMO and the Department, **as to** the appropriate covered health care services the member should receive.

(k) The IURO's determination shall be binding on the HMO and the member, except to the extent that other remedies are available to either party under State or Federal law. The HMO shall provide benefits (including payment on the claim) pursuant to the IURO's determination without delay, regardless of whether the HMO intends to seek judicial review of the external review decision, unless there is a judicial decision stating otherwise. Within 10 business days of the receipt of the determination of the IURO as set forth in (j) above, the HMO shall submit a written report to the IURO, member and provider if the provider made the appeal on behalf of the member with the member's consent[,] and the Department indicating [whether] **how** the HMO will [accept and] implement [or reject the recommendations of the IURO in whole or in part] **the IURO's determination.**

[1. The written report of the HMO shall state with specificity the reasons for rejection, in whole or in part, of the recommendation(s) of the IURO, and the HMO's report shall not be complete unless such reasons are set forth in the report.]

1. The HMO shall specify its intentions sooner if the medical exigencies of the case warrant a more rapid response.

(l) (No change.)

(a) – (c) (No change.)

(d) An IURO must have external review accreditation from a nationally recognized private accrediting organization, such as URAC.

[11:24-8.9 Department review of HMO actions on IURO recommendations

(a) The Department shall review records of HMO reports submitted pursuant to N.J.A.C. 11:24-8.7(k) at least annually to determine whether a carrier exhibits a pattern of noncompliance with the recommendations of an IURO as well as possible violations of patient rights or other applicable laws.

(b) If the Department determines that an HMO exhibits a pattern of noncompliance with the recommendations of an IURO, the Department shall review:

1. Whether the HMO's noncompliance is with a specific set of recommendations;
2. Whether the HMO's noncompliance is with a specific IURO (in the event more than one IURO participates in the external appeal program); and
3. The HMO's utilization management program.

(c) If the Department determines that the HMO's utilization management program is not in compliance with either the HMO's utilization management standards set forth in accordance with N.J.A.C. 11:24-8.1, or other relevant laws, the Department shall take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 11:24-2.14.

(d) If the Department determines that the HMO is in violation of member rights or other applicable requirements, the Department shall take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 11:24-2.14.

(e) A pattern of noncompliance shall include, but not be limited to, multiple incidents of refusal to follow the recommendations of the IURO, in whole or in part, within a 12 month period, when such recommendations require the HMO to provide covered services or benefits therefor to a member.]

CHAPTER 24A

HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS[,] AND MEDICAL SERVICE CORPORATIONS

SUBCHAPTER 1. GENERAL PROVISIONS

11:24A-1.2 Definitions

For the purposes of this chapter, the words and terms set forth below shall have the following meanings, unless the word or term is further defined within a subchapter of this chapter, or the context clearly indicates otherwise[.]:

...

“Adverse benefit determination” means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment

(in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.

...

"Claim" means a request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies covered under a health benefits plan issued by a carrier.

...

"Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a carrier at the completion of the internal appeal process, an adverse benefit determination with respect to which the carrier has waived its right to an internal review of the appeal, an adverse benefit determination for which the carrier did not comply with the requirements of N.J.A.C. 11:24A-3.4 or 3.5 and an adverse benefit determination for which the covered person or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

...

"Post-service claim" means any claim for a benefit that is not a "pre-service claim."

"Pre-service claim" means any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

...

"Urgent care claim" means any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or which, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

...

SUBCHAPTER 3. UTILIZATION MANAGEMENT

11:24A-3.2 Disclosure requirements

(a) In addition to the requirements of N.J.A.C. 11:24A-2.3, carriers shall include in the disclosure statements a covered person's right to appeal to the carrier [a denial,

reduction or termination of health care services or the payment of benefits therefor resulting from a utilization management decision by or on behalf of a carrier,] **an adverse benefit determination, except where the adverse benefit determination was based on eligibility, including rescission, or on the application of a contract exclusion or limitation not relating to medical necessity,** setting forth:

1. – 3. (No change.)

(b) The statement that a covered person has a right to appeal a carrier's [utilization management decision] **final adverse benefit determination, except where the final adverse benefit determination was based on eligibility, including rescission, or on the application of a contract exclusion or limitation not relating to medical necessity,** at the option of the covered person through the Independent Health Care Appeals Program, including:

1. – 2. (No change.)

3. A statement that the covered person [must] **shall have a minimum four-month period to** file the application for review of the carrier's final [decision within 60 days] **adverse benefit determination** following the date the final [decision] **internal adverse benefit determination** was issued by the carrier; and

4. (No change.)

11:24A-3.4 Utilization management program

(a) – (c) (No change.)

(d) The carrier shall have written policies and procedures, available for review by the Department upon request, that address the responsibilities and qualifications of staff who render determinations to authorize admissions, services, procedures or extensions of stay meeting the following:

1. All determinations to deny or limit an admission, service, procedure or extension of stay, or benefits therefor, shall be made in accordance with the clinical and medical necessity criteria developed in accordance with (b) above, and rendered by a physician under the clinical direction of the medical director required pursuant to N.J.A.C. 11:24A-3.3.

i. (No change.)

ii. The physician rendering the determination shall be available immediately to the treating provider in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation[.];

2. All determinations shall be made on a timely basis, as required by the exigencies of the situation[.]; **and**

3. A carrier shall notify a provider and/or covered person of a determination concerning an urgent care claim and determined by the attending provider as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim by the carrier, of a determination concerning a non-urgent pre-service claim (that is, prior authorization) no later than 15 days after receipt of the pre-service claim by the carrier, and of a determination concerning post-service

claims no later than 30 days after receipt of the post-service claim by the carrier.

(e) A carrier shall not [deny reimbursement retroactively for a covered service provided to a covered person by a] **reverse a utilization management decision where the** provider [who] relied upon the written or oral authorization of the carrier (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

(f) A carrier shall provide written notice within [five days, or sooner if the medical exigencies dictate, upon request,] **two business days** of any determination to deny coverage or authorization of services or payment of benefits therefor otherwise covered under the contract or policy of the covered person, and shall include an explanation of the appeal process.

11:24A-3.5 Internal [utilization management] **adverse benefit determinations**
appeals process

(a) A carrier shall establish an appeal process whereby a covered person or a provider acting on behalf of the covered person, with the covered person's consent, may appeal [any UM decision resulting in a denial, termination or limitation of services or the payment of benefits therefor covered under the contract or policy.] **an adverse benefit determination, except where the adverse benefit determination was based on eligibility, including rescission, or the application of a contract**

exclusion or limitation not related to medical necessity, within 180 days of receipt of the adverse benefit determination.

(b) Carriers shall detail the appeal process in a writing provided to covered persons at the time of coverage (and periodically as changes occur), upon the occurrence of [a utilization management decision adverse to the request of the covered person,] **an adverse benefit determination, and** upon the conclusion of each stage of the appeal process[, and upon request].

(c) Carriers shall provide a written description of the appeal process and the carrier's [decision on an appeal] **adverse benefit determination** to providers [upon request, and] upon the conclusion of each stage of the appeal process, when the provider is making the appeal on behalf of a covered person with the covered person's consent.

(d) (No change.)

(e) [Carriers] **For covered persons in group health benefits plans, carriers** shall establish an **internal** appeal process in two stages, with the stage 1 appeal being an informal process, and stage 2 being a formal process. **For covered persons in individual health benefits plans, the internal appeal process shall consist of a stage 1 informal process.**

(f) **A carrier must provide the covered person and/or the provider acting on behalf of the covered person, free of charge, with any new or additional evidence or rationale, which will be relied upon, considered or utilized, or generated by the carrier (or at the direction of the carrier) in**

connection with the pre-service or post-service claim. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the initial decision or the decision at the stage 1 appeal or stage 2 appeal is rendered in order to give the covered person or provider a reasonable opportunity to respond prior to that date.

(g) An appeal concerning an urgent care claim may be submitted orally or in writing.

(h) The initial adverse benefit determination, as well as an adverse benefit determination following a stage 1 or stage 2 appeal, shall be culturally and linguistically appropriate pursuant to 45 CFR 147.136(e) and shall include:

1. Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Any such request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to as soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal;

2. The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by the carrier in the denial; and

3. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24A-3.6(b).

(i) A carrier shall provide continued coverage of an ongoing course of treatment pending the outcome of a stage 1 internal appeal, a stage 2 internal appeal and an external appeal.

[(f)] **(j)** Carriers shall provide in stage 1 for a covered person (or his or her designated provider if the covered person has consented to having a provider act in his or her behalf) to have an opportunity to speak, regarding an adverse [service or] benefit[s] determination, with the carrier's medical director, or the medical director's designee who rendered the adverse **benefit** determination.

1. Stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, but in no event shall exceed:

i. [72] **Seventy-two** hours in the case of an appeal from [a] **an adverse benefit** determination regarding urgent or emergency care [(which shall include all situations in which the covered person is confined in an inpatient facility)], **an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility**; and

ii. [Five business] **Ten calendar** days in the case of all other appeals.

2. At the conclusion of stage 1, the carrier shall include a written explanation of the covered person's right to [make] **file** a stage 2 appeal[, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.] **for persons covered by a group health benefits plan, or to file an appeal with the Independent Health Care Appeals Program for persons covered by an individual health benefits plan, including the applicable time limits for filing the appeal, and to whom the stage 2 appeal should be addressed for persons covered by group health benefits plans or the form required to initiate an appeal with the Independent Health Care Appeals Program for persons covered by an individual health benefits plan.**

[(g)] **(k)** Carriers shall provide in stage 2 appeals for a covered person (or the covered person's designated provider, if the covered person has consented to have a provider act in his or her behalf) to pursue his or her appeal before a panel of physicians and/or other providers selected by the carrier who have not been involved in the [UM decision] **adverse benefit determination** at issue.

1. The panel shall [have access to] **include** consultant providers who are trained or who practice in the same specialty as would typically manage the case at issue[, or such other licensed provider as may be mutually agreed upon by the parties].

[i.] The consulting provider(s) shall not have been involved in the [UM decision] **adverse benefit determination** at issue.

[ii. The carrier shall allow the consulting provider(s) to participate with the panel in the review of the case if so requested by the covered person (or the covered person's designated provider if the covered person has consented to having a provider act in his or her behalf).]

2. The carrier shall send to the covered person (or designated provider if the covered person has consented to having a provider act in his or her behalf) an acknowledgment of the filing of a stage 2 appeal in writing within no more than 10 business days of receipt by the carrier of the appeal.

3. The carrier shall conclude the stage 2 appeal as soon as possible after receipt of the appeal by the carrier in accordance with the medical exigencies of the case, but in no event shall **the time to conclude the stage 2 appeal** exceed[:

i.] 72 hours in the case of appeals of determinations regarding urgent or emergent care, [(which shall include all situations in which the covered person is confined in an inpatient facility); and

ii.] **an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility, and which in no event shall exceed 20 business days** in the case of all other appeals.

[4. Notwithstanding (g)3ii above, a carrier may extend the review period for up to an additional 20 business days where the carrier can demonstrate reasonable cause for the delay beyond its control, but only if the carrier provides a written progress report and explanation for the delay to the satisfaction of the Department and written

notice to the covered person and provider, as appropriate, within the original 20 business day review period.]

[5.] **4.** (No change in text.)

[6. A carrier shall not provide a stage 2 appeal to any covered person (or the covered person's designated provider if the covered person has consented to having a provider act in his or her behalf) until a covered person's right to a stage 1 appeal is exhausted.]

(I) A covered person and/or provider shall be relieved of his or her obligation to complete the carrier's internal review process and may, at his or her option, proceed directly to the external appeals process set forth at N.J.A.C. 11:24A-3.6 if:

1. The carrier fails to comply with any of the deadlines for completion of the internal adverse benefit determination appeals set forth in this section unless the carrier's violation does not cause, and is not likely to cause, prejudice or harm to the covered person and/or provider, so long as the carrier demonstrates that the violation was for good cause or due to matters beyond the control of the carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the carrier and the covered person and/or provider, and is not reflective of a pattern or practice of non-compliance by the carrier.

i. The covered person and/or provider may request a written explanation of the violation from the carrier, and the carrier shall

provide such explanation of the violation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

ii. If an external reviewer or a court rejects the covered person's and/or provider's request for immediate review on the basis that the carrier met the standards for the exception set forth in this paragraph, the covered person and/or provider has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review, not to exceed 10 days, the carrier shall provide the covered person and/or provider with notice of the opportunity to resubmit and pursue the internal appeal. The time period for refiling the claim shall begin to run upon the covered person's and/or provider's receipt of such notice;

2. The carrier for any reason expressly waives its rights to an internal review of any appeal; or

3. The covered person and/or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

(a) Any covered person, and any provider acting on behalf of a covered person with the covered person's consent, [who is dissatisfied with the final results of a carrier's internal appeals process shall have the right to pursue his or her] **may appeal a final internal adverse benefit determination, except where the final internal adverse benefit determination was based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity**, through the Independent Health Care Appeals Program to an independent IURO.

[1. A covered person and any provider acting on behalf of a covered person with the covered person's consent shall exhaust all appeal rights he or she may have under the policy or contract with the carrier prior to making application to pursue an appeal through the Independent Health Care Appeals Program, except that the covered person and any provider acting on behalf of a covered person with the covered person's consent shall be relieved of the carrier's internal appeal process and may pursue an appeal through the Independent Health Care Appeals Program if:

i. A determination on any appeal regarding urgent or emergency care is not forthcoming from the carrier within 72 hours of receipt by the carrier of notice (in the manner required under the policy or contract) of the appeal;

ii. A determination on an initial appeal, other than one regarding urgent or emergency care, is not forthcoming from the carrier within five business days of the date that the carrier received notice (in the manner required under the policy or contract) of the appeal; or

iii. A determination of a subsequent level of appeal, other than one regarding urgent or emergency care, is not forthcoming from the carrier within 20 business days of the date that the carrier received notice (in the manner required under the policy or contract) of the appeal, except as N.J.A.C. 11:24A-3.5(g)4 applies.

2. A covered person and any provider acting on behalf of a covered person with the covered person's consent dissatisfied with the carrier's appeal process for reasons set forth in (a)1i, ii, or iii above shall certify on the appeal form that one or more determinations from the carrier have exceeded the time frames set forth in (a)1i, ii or iii above, and that the covered person or the covered person's provider have in no way hindered the carrier in making the determination by failing to provide the carrier with all requested information relevant to the determination.

3. A covered person and any provider acting on behalf of a covered person with the covered person's consent who has exhausted all of his or her appeal rights shall certify on the application that he or she has exhausted all levels of appeal to which he or she is entitled under the contract or policy.]

(b) To initiate an appeal through the Independent Health Care Appeals Program, a covered person or provider acting on behalf of a covered person with the covered person's consent shall[, within 60 days] **have a minimum four-month period** from the date of receipt of the carrier's final **internal adverse benefit** determination[, or the last date of filing of an appeal by the covered person or provider in the situation in which the covered person or provider acting on behalf of a covered person with the covered person's consent believes the carrier has failed to meet required time frames,]

to file [an application with the Department. The application form can be accessed on the Department's website at <http://www.state.nj.us/dobi/chap352/352ihcapform.doc>. The application requests the name of the covered person/subscriber, the person filing the appeal, the name of the provider, information regarding any prior appeal(s), a summary of the appeal issues and authorization by the covered person for release of information.] **a written request with the Department for an IURO appeal. The request shall be filed on the forms automatically provided to the covered person in accordance with N.J.A.C. 11:24A-3.5(k)4, and shall include both the fee specified in (c) below and a general release executed by the covered person for all medical records pertinent to the appeal. The request shall be mailed to the following address:**

[1. The covered person or provider acting on behalf of a covered person with the covered person's consent shall complete the application, including the certification applicable to the covered person's situation, and shall submit with the application:

i. The fee as specified in (c) below, along with evidence demonstrating financial hardship, if appropriate; and

ii. A general release executed by the covered person for all medical records pertinent to the appeal.

2. The covered person or provider acting on behalf of a covered person with the covered person's consent shall mail the application to:]

Department of Banking and Insurance

Consumer Protection Services

Office of Managed Care

PO Box [325] **329**

Trenton, New Jersey 08625-[0325]**0329**

(888) 393-1062

[(c) The covered person or provider acting on behalf of a covered person with the covered person's consent shall submit a fee of \$ 25.00 per application, unless there is submitted with the application a demonstration of the covered person's financial hardship, in which event, the covered person may submit no fee until a decision is made by the Department as to whether the covered person qualifies for a reduced fee based on financial hardship.

1. The Department will determine a covered person eligible for a reduced fee on the basis of financial hardship if the covered person submits evidence that one or more members of the household is receiving assistance from the Pharmaceutical Assistance to the Aged and Disabled program, Medicaid, NJ KidCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

2. A covered person determined to be eligible for a reduced fee because of financial hardship shall submit a fee of \$2.00.

3. The fee for filing an appeal shall be made payable by check or money order to the "New Jersey Department of Banking and Insurance."]

(c) The fee for filing an IURO appeal shall be as follows:

1. Covered persons shall pay a \$25.00 filing fee, payable by check or money order to the "New Jersey Department of Banking and Insurance." The filing fee shall be refunded to the covered person if the final internal adverse benefit determination is reversed by the IURO;

2. Upon a determination of financial hardship, the fee shall be waived. Financial hardship may be demonstrated by the covered person through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI or New Jersey Unemployment Assistance; and

3. Annual filing fees for any one covered person shall not exceed \$75.00.

(d) Upon receipt of the [application, together with the executed release and the appropriate fee,] **request for appeal from** the Department, [shall immediately assign the appeal to an IURO meeting the requirements of N.J.A.C. 11:24A-5.

(e) Upon receipt of the application,] the IURO shall conduct a preliminary review of the [application] **appeal** and accept it for processing if it determines that:

1. (No change.)

2. The service that is the subject of the appeal reasonably appears to be a service covered under the terms of the contract or policy for which some level of benefit is payable; **and**

[3. The covered person or provider acting on behalf of a covered person with the covered person's consent has fully complied with the internal appeals process of the carrier, except as (a)1i, ii or iii above may apply; and]

[4.] **3.** The covered person or provider acting on behalf of a covered person with the covered person's consent has provided all information required by the IURO and the Department to make a preliminary determination, including **the appeal form and** a copy of any information provided by the carrier regarding its [decision to deny, reduce or terminate the covered service or payment of benefits therefor] **final adverse benefit determination**, and [an executed] **a fully-executed** release [of] **to obtain any** necessary medical records from the carrier and any relevant provider.

[(f)] **(e)** Upon completion of the preliminary review, the IURO immediately shall notify the [member] **covered person** and/or provider in writing as to whether the [application] **appeal** has been accepted for processing [of the appeal], and if not, the reasons therefor. **The IURO shall additionally notify the covered person and/or provider of his or her right to submit in writing, within five business days of receipt of the notice of acceptance of his or her appeal, any additional information to be considered in the IURO's review. The IURO shall provide the carrier with any such additional information within one business day of receipt of the information.**

[(g)] **(f)** Upon acceptance of the [application] **appeal** for processing [of the appeal], the IURO shall conduct a full review to determine whether, as a result of the carrier's [decision] **final internal adverse benefit determination**, the carrier

inappropriately denied services, or the payment of benefits therefor, for the provision of medically necessary treatment or supplies that were/are covered under the contract or policy, taking into consideration the following:

1. - 3. (No change.)

[(h)] **(g)** The IURO [shall conduct its initial full review through a registered professional nurse or physician licensed to practice in New Jersey, and, when necessary,] shall refer all cases for **full review, as referenced in (f) above,** to [a consultant] **an expert** physician in the **same** specialty or area of practice that generally would manage the type of treatment that is the subject of the appeal, but shall not render a final recommendation except with the approval of the IURO's medical director, **who shall be a physician licensed to practice in New Jersey.**

[(i)] **(h)** The IURO shall complete its review and issue its decision in writing as soon as possible consistent with the medical exigencies of the case, but in no instance later than [30 business] **45** days following the date of receipt of the [appeal application, unless additional review time is necessitated by circumstances beyond the control of the IURO] **request for IURO review.**

[1. In the event that the IURO may not complete its review within 30 business days, the IURO shall provide written notice to the covered person and his or her provider, the Department and the carrier of this fact prior to the completion of the 30 business day review, but in no event shall the IURO render its decision later than 90 days following receipt of a complete application.

2. The IURO shall specify in the written notice the reasons for the delay, the status of the review, and the anticipated completion date of the full review.]

[(j)] **(i)** Notwithstanding [(i)] **(h)** above, if the appeal involves care for an urgent or emergency case, **an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function**, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal. **If the IURO's determination of the appeal provided within no more than 48 hours was not in writing, the IURO shall provide written confirmation of its determination within 48 hours of providing the verbal determination.**

[(k)] **(j)** The IURO shall set forth in its written decision whether the IURO has determined that the covered person was deprived of [receipt of or benefits for] **coverage of** medically necessary services [otherwise covered under his or her contract or policy,] and, if so, shall specify the **appropriate covered** services the covered person should receive [or receive benefits therefor].

1. (No change.)

2. The IURO's determination shall be binding on the carrier and the covered person, except to the extent that other remedies are available to either party under State or Federal law. The carrier shall provide

benefits (including payment on the claim) pursuant to the IURO's determination without delay, regardless of whether the carrier intends to seek judicial review of the external review decision, unless there is a judicial decision stating otherwise.

11:24A-3.7 Carrier action on the IURO decisions

(a) (No change.)

[(b) A carrier that implements one or more of the recommendations of an IURO shall not be liable in any action for damages to any person for any action taken to implement a recommendation.]