NEW JERSEY HOSPITAL ASSOCIATION
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THE NEW JERSEY PROVIDER APPEALS PROCESSES

Utilization Management Appeals

Independent Health Care Appeals Program (IHCAP)

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The Health Care Quality Act, the Health Claims Authorization, Processing and Payment Act and regulations at N.J.A.C. 11:24-8 all establish the procedure that may be accessed in the event a carrier issues a decision to deny, terminate or limit a person's access to health services.

With the advent of managed care came the introduction of utilization management (UM) processes to determine the medical necessity and appropriateness of health care services provided to patients in order to contain cost. Subsequently, appeals processes were developed in order to assure that health plans were not merely denying services as a way to lower cost.

In New Jersey, the process by which UM determinations are reviewed is governed by both statute and regulation. The Health Care Quality Act, the Health Claims Authorization, Processing and Payment Act and regulations at N.J.A.C. 11:24-8 all establish the procedure that may be accessed in the event a carrier issues a decision to deny, terminate or limit a person's access to health services. Together these requirements create a three stage appeal process for group health insurance and a two stage appeal process for individual health insurance. The process affords patients and providers an opportunity to appeal a denial for services that was made as part of a utilization management review.

This toolkit provides resources that will assist hospitals in properly processing appeals that address the medical necessity of services including a summary of relevant regulatory and legislative provisions, a checklist to ensure the appropriate procedures are followed, sample letters to use when corresponding with health plans and the necessary forms that must accompany and appeal.

Relevant Regulatory and Legislative Provisions:

- A health plan's decision to deny, reduce or terminate a healthcare benefit, or to deny payment for a healthcare service, based on medical necessity, must be made by a physician, who must directly communicate his or her decision to the provider. In the event this is not possible, the provider must be supplied with the name, telephone number and information on where the physician making the determination can be reached.
- Prior to receiving hospital services, a covered person or their designee, may sign a consent form authorizing a health care provider to act on the covered person's behalf to appeal a carrier's determination. The consent form is valid for all stages of the appeals process and in these instances, a healthcare provider must provide notice to a covered person whenever initiating an appeal and at each subsequent level of the appeal.

- The appeals review shall not include any decisions regarding benefits not covered by the covered person's health benefits plan.
- Utilization management determinations must be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers within the network and based upon generally accepted medical standards.
- A carrier must make their clinical criteria and protocols readily available, upon request, with the exception of internal or proprietary quantitative thresholds for utilization management with the exception of internal or proprietary quantitative thresholds for utilization management.
- A carrier must provide the member, or the provider acting on the member's behalf, with any new or additional evidence or rationale which will be relied upon, considered, utilized or generated by the carrier when making an adverse benefit determination.
- All Stage 2 appeals for group health benefit plan members, must afford the patient or provider an opportunity to appeal to a panel of physicians or other health care professionals selected by the carrier that have not been involved in the adverse determination at issue.
- Upon receipt of the appeal request, together with the executed release DOBI will assign the appeal to an IURO for review.
- The IURO will perform a preliminary review of the appeal and accept it if:
  - The patient was or is a member of the managed care organization;
  - The service which is the subject of the appeal reasonably appears to be a covered service under the benefits provided to the patient;
  - The two stage internal appeal process was complied with;
  - All necessary information required by the IURO and DOBI including the appeal form and a copy of any information provided by the managed care organization regarding its decision and a fully executed release to obtain any necessary medical records from the managed care organization and any other relevant health care provider is included.
- Upon completion of the preliminary review the IURO will notify the patient or provider in writing acknowledging if the appeal has been accepted. If not, the IURO will provide the reasons for its rejection.
- The IURO must also notify the patient or provider in writing within five business days of any additional information to be considered in the IURO's review, if the appeal is accepted.
- The IURO's determination is binding on all parties.
- If the IURO's determination finds for the patient the managed care organization must provide the benefits without delay. The managed care organization has 10 business days of receipt of the determination to submit a written report to the IURO, the patient, the provider if they made the appeal on the patient's behalf, and DOBI indicating how the IURO's determination will be implemented.

Stage One Informal Appeal Process – Internal to MCO (Reconsideration)

The informal stage one appeal process is often referred to as a "reconsideration". It may be submitted either orally or in writing. It is addressed directly with the medical director or physician that made the initial determination.

Ensure the adverse determination is not **greater than 180 days old**. Date of initial determination: _____

(**note**: *Federal law requires that people enrolled in group health plans have at least 180 days following an adverse UM determination to file for a Stage 1 UM appeal. In instances when an individual is covered under an individual policy or Medicaid managed care the Department encourages carriers to comply with the 180-day standard across all of their lines of business. However, some carriers may specify a shorter timeframe for filing Stage 1 or Stage 2 UM appeals.*)

Ensure a signed copy of the patient's consent to appeal form is on file.
http://www.state.nj.us/dobi/chap352/352implementnotice.html#formsandinstructions

Provide the patient with notice that a level one appeal is being filed. Date Sent: _____
http://www.state.nj.us/dobi/chap352/352implementnotice.html#formsandinstructions

File the necessary information directly to the MCO's medical director or the physician who issued the denial. Date Sent: _____

Set the "clock" on the appeal: Anticipated Date/Time: _____

- An MCO must conclude the appeal within **72 hours** for cases involving urgent or emergency care.
- An MCO must conclude the appeal within **ten calendar days** for all other cases.
- Ensure the appropriate deadlines for a response have been met. Date/Time Received: _____
  If not met, provider can move to Stage 3.

Ensure the MCO has provided a written explanation of a subscriber's right to proceed to the second level of appeal and provided the applicable time limits if any as well as to whom the appeal must be addressed.

Determine if the appeal has been addressed satisfactorily, if not access the second level of appeal.

Stage Two Formal Appeal Process – Internal to MCO

The more formal, level 2 process, requires that an MCO establish a panel of health care professionals that meet minimum requirements including: none of the professionals on the panel were involved in the stage one appeal and consultant practitioners are available who are trained or who practice in the same specialty area at issue, or such other licensed health care professional as may be mutually agreed upon by the parties.

Ensure you are filing within the plan's proscribed deadlines. Deadline: _____

Include another signed copy of the patient's consent to appeal form.
http://www.state.nj.us/dobi/chap352/352implementnotice.html#formsandinstructions

Provide the patient with notice that a level two appeal is being filed. Date Sent: _____
http://www.state.nj.us/dobi/chap352/352implementnotice.html#formsandinstructions

Ensure the MCO acknowledges receipt of the appeal in writing to the member or provider filing the appeal **within 10 business** days of receipt of the appeal. Date Received: _____

Set the "clock" for written acknowledgement from the MCO as well as determination deadlines. Anticipated Date/Time: _____

- An MCO must conclude the appeal within **72 hours** for cases involving urgent, emergency or concurrent inpatient care.
- An MCO must conclude the appeal within **20 business days** for all other cases.
- An MCO may extend the decision another 20 days if 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 DOBI.

Ensure the appropriate deadlines for a response have been met. Date/Time Received: _____
If not met, provider can move to Stage 3.

Ensure that an MCO provides all of the following information, in writing with a stage 2 denial:

- all the reasons for the denial;
- instructions on how to arrange for an external appeal; and
- any forms to be filed with the external appeal.

Stage Three – Formal External Review

The third stage of the appeal process allows patients and providers an opportunity to request an outside party review their appeal – this is known as the Independent Health Care Appeals Program. The appeal is overseen by an independent utilization review organization (IURO) contracted under DOBI. All decisions made by the IURO are binding.

Ensure that the appeal is filed no later than 4 months after the Stage 2 adverse determination. Deadline for Filing: _____

Ensure that the appropriate form is being used. The form must include:

- The name and business address of the carrier; ❑ yes ❑ no
- A brief description of the patient's medical condition associated with the adverse determination; ❑ yes ❑ no
- A copy of any information provided by the carrier regarding the adverse determination ; and ❑ yes ❑ no
- A written consent to obtain any necessary medical records from the carrier and any out-of-network physician the patient may have consulted on the case. ❑ yes ❑ no

Ensure appropriate payment accompanies the appeal. A filing fee of $25 must be included at the time the form is submitted. If the form is submitted by a provider on behalf of a member the provider bears all financial cost. Check Number: _____

File request for appeal to: Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329

The IURO will provide written notification upon completion of a preliminary review whether the appeal is accepted for processing.

If the appeal involves urgent or emergency care, an admission, availability of care, continued stay, health care services for which a patient 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 must complete its review within no more than 48 hours following its receipt of the appeal. Anticipated Date/Time: _____

All other appeals to an IURO must be completed within 45 days of receipt of the request for IURO review.

If the IURO's determination finds for the patient the managed care organization must provide the benefits without delay. The managed care organization has 10 business days of receipt of the determination to submit a written report to the IURO, the patient, the provider if they made the appeal on the patient's behalf, and DOBI indicating how the IURO's determination will be implemented. Implementation Report Due: _____

Sample Letters

SAMPLE LETTER TO HMO

(Reporting Violations of **HCAPPA Prompt Payment** Requirements)

Date

Ms. Jane Doe
HMO's Name
123 Main Street
Main, NJ 12345

Dear

Pursuant to P.L.2005, c.352, the Health Claims Authorization, Processing and Payment Act (HCAPPA), you are required to make payment for every insured claim submitted by a covered person or health care provider within 30 calendar days or no later than the time limit established for the payment of claims in the Medicare program (whichever is earlier) for claims submitted electronically and within 40 calendar day for claims submitted by other than electronic means. Failure to do so will result in a payment of 12 percent simple interest on those overdue claims.

Our records indicate there exists an outstanding balance with (*insert HMO's name*) on the following claims:

_____

_____

_____

Please send your check for these outstanding claims *with the accrued interest* to my attention. Should you require assistance with the processing of these claims, you may contact me at (*insert your telephone #*). Failure to act on your part reflects a violation of existing statute and will, therefore, be subject to the appeals process as established by the HCAPPA.

Sincerely,

Hospital Representative

NEW JERSEY HOSPITAL ASSOCIATION
NJHA

SAMPLE LETTER TO HMO

(Reporting Violations of **Utilization Management** Requirements under HCAPPA)

Date

Patient Name:
Patient ID#:
Date of Service:

Dear Medical Director:

The Health Claims Authorization, Processing and Payment Act (HCAPPA) requires that "any denial of a request for authorization or limitation imposed by a payer on a requested service shall be made by a physician under the clinical direction of the medical director who shall be licensed in this State and shall be communicated to the hospital or physician by facsimile, e-mail or other means of written communication agreed to by the payer and hospital" P.L. 2005 c. 352. HCAPPA further stipulates that authorization for services must be rendered as follows:

- For prior authorization for a covered person who will receive inpatient hospital services a decision must be rendered within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made.
- For authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, a decision must be rendered within a time frame appropriate to the medical exigencies of the case but no later than 24 hours following the time the request was made.
- For prior authorization for a covered person who will receive health care services in an out-patient or other setting including but not limited to a clinic, rehabilitation facility or nursing home a decision must be rendered within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made.

Information regarding this case was forwarded to you on (*insert dates)*. We did not receive your determination until (*insert date)*.

According to the above statutory provisions, (*insert HMO name*) did not provide a timely response to (*insert your hospital's name*) utilization management request for authorization for services.

As HCAPPA further clarifies "if a payer fails to respond to an authorization request within the established times frames" the "hospital or physician's request shall be deemed approved and the payer shall be responsible to the hospital or physician for the payment of the covered services delivered." P.L. 2005, c. 352

We therefore request that all days be paid at the acute level. Failure to reverse this decision will result in a complaint being filed with the Department of Banking and Insurance.

Sincerely,

Hospital Representative

NEW JERSEY HOSPITAL ASSOCIATION
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SAMPLE LETTER TO HMO

(Reporting Violations of **Appeals** Regulations)

Date

Patient Name:
Patient ID#:
Date of Service:

Dear Medical Director:

I am writing in reference to the above case. (*Insert your hospital's name*) records indicate that in reviewing and/or adjudicating this claim, (*insert HMO's name*) failed to act in accordance with New Jersey HMO regulations.

Specifically, N.J.A.C. 11:24-8.6(f) states that "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.

(Insert your hospital's name) filed its appeal on *(insert date)* and did not receive a response from *(insert HMO's name)* until *(insert date)* therefore, we will bypass the Stage 2 appeal process and immediately begin accessing the external appeals process.

Sincerely,

Hospital Representative

NEW JERSEY HOSPITAL ASSOCIATION
NJHA

SAMPLE LETTER TO HMO

(Reporting Violations of **Retrospective Denials**)

Date

Patient Name:
Patient ID#:
Date of Service:

Dear

We are in receipt of your determination to deny payment for the above referenced patient. Your action is in violation of state law.

The Health Claims Authorization, Processing and Payment Act (HCAPPA) expressly states that "no payer, or payer's agent shall deny reimbursement to a hospital on the grounds of medical necessity absent fraud or misrepresentation….if the hospital or physician requested authorization from the payer and received approval for the health care services delivered prior to rendering the service."

Further N.J.A.C. 11:24-8.3(d) prohibits an HMO from denying reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member.

As indicated in (*insert your hospital's name*) claim for the above patient submitted on (*insert date*), (*insert your hospital's name*) requested *and obtained* from (*insert HMO name*) authorization to provide services *prior to* (*insert your hospital's name*) rendering of the service to the member. Documentation of this preauthorization number was included in the claim.

In accordance with N.J.A.C. 11:24-8.3(d), (*insert your hospital's name*) is anticipating a reversal of (*insert HMO name*) decision. Should we not receive payment for this case within two weeks, we will forward all appropriate documentation substantiating violation of N.J.A.C. 11:24-8.3(d) to the New Jersey Department of Banking and Insurance and request an investigation into this matter.

Sincerely,

President and CEO

NEW JERSEY HOSPITAL ASSOCIATION
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