

(b) Utilization management determinations shall 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. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to members and participating providers in the relevant practice areas.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

In (a), inserted "by the HMO, and is available for review by the Department upon request" at the end of the second sentence in the introductory paragraph.

8:38-8.2 Utilization management staff availability

(a) A registered professional nurse or physician shall be immediately available by phone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(b) For routine utilization-related inquiries, the HMO shall provide all members and providers with a toll free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis.

(c) All members must have immediate phone access seven days a week, 24 hours a day, to their primary care provider or his or her authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

8:38-8.3 Utilization management determinations

(a) The HMO shall have written policies and procedures that address responsibilities and qualifications of staff who render determinations to authorize admissions, services, procedures or extensions of stay.

(b) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The determination shall be directly communicated by the physician to the provider or, if this is not possible, the provider shall be supplied with the physician's name, telephone number, and where he or she can be reached. The physician shall be available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the HMO's New Jersey members. Such determinations shall be made in accordance with clinical and medical necessity criteria developed pursuant to N.J.A.C. 8:38-8.1(b) and the evidence of coverage.

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

(d) An HMO shall not retroactively deny 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, 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. 8:38-8.5, 8.6 and 8.7. The written notice of determination shall include an explanation of the appeal process.

8:38-8.4 Appeals of utilization management determinations

(a) All HMO members, and any provider acting on behalf of a member with the member's consent, may appeal any utilization management determination resulting in a denial, termination, or other limitation of covered health care services in accordance with the provisions of N.J.A.C. 8:38-8.5 through 8.7. 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. 8:38-8.5 through 8.7. 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. 8:38A-5.

(b) Nothing in the HMO's policies, procedures or provider agreement shall prohibit a member or provider (on behalf of a member) from discussing or exercising the right to an appeal available under N.J.A.C. 8:38-8.5 through 8.7.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

In (a), added "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. 8:38A-5" at the end.

8:38-8.5 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 determination, 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), and five business 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.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote the second and third sentences.

8:38-8.6 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 or any provider acting on behalf of a member 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 determination at issue.

(b) The formal internal utilization management appeal panel shall 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. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management 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) All such stage 2 appeals shall be acknowledged by the HMO, in writing, to the member or provider filing the appeal within 10 business days of receipt.

(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, 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) If the stage 2 appeal is denied, the HMO shall provide the member and/or provider with written notification of the denial and the reasons therefor together with a written notification of his or her right to proceed to an external (stage 3) appeal. This notification shall include specific instructions as to how the member and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

(g) In the event that the HMO fails to comply with any of the deadlines for completion of the internal utilization management determination appeals set forth in N.J.A.C. 8:38-8.5 or 8.6, or in the event that 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. 8:38-8.7.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

In (d), inserted "(including all situations in which the member is confined as an outpatient)" following "care".

8:38-8.7 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. 8:38-8.5 through 8.6 above, shall have the right to pursue his or her appeal 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. 8:38-8.6(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. 8:38-8.5 and 8.6.

(b) To initiate an external appeal, a member and/or provider shall, within 60 days from receipt of the written determination of the stage 2 internal appeal panel under N.J.A.C. 8:38-8.6(f), file a written request with the Department. The request shall be filed on the forms automatically provided to the member in accordance with N.J.A.C. 8:38-8.6(f), 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 Health and Senior Services
Office of Managed Care
Division of Health Care Systems Analysis
PO Box 360
Trenton, New Jersey 08625-0360

(c) The fee for filing an appeal shall be \$25.00, payable by check or money order to the "New Jersey Department of Health and Senior Services." Upon a determination of financial hardship, the fee may be reduced to \$2.00. 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 Kid-Care, General Assistance, SSI, or New Jersey Unemployment Assistance.