

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.

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 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. 11:24-8.5 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. 11:24-8.7.

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".

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 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. 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 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. 11:24-8.6(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. 11:24-8.6(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 Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 325
Trenton, New Jersey 08625-0325

(c) The fee for filing an appeal shall be \$25.00, payable by check or money order to the "New Jersey Department of Banking and Insurance." 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 KidCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

(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. The individual was or is a member of the HMO;
2. The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the member;
3. Except as set forth at N.J.A.C. 11:24-8.6(g), the member has fully complied with both the stage 1 and stage 2 appeals available pursuant to N.J.A.C. 11:24-8.5 and 8.6; and
4. The member has provided all information required by the IURO and 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.

(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 determination, the member was deprived 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 IURO shall refer all cases for review to a consultant 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 of the IURO shall be approved by the medical director of the IURO.

(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 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.

1. Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

(j) If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend to the member and/or provider who filed the appeal, the HMO and the Department, the appropriate covered health care services the member should receive.

(k) 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 the HMO will accept and implement or reject the recommendations of the IURO in whole or in part.

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.

(l) Nothing in this section shall limit the authority of the Division of Medical Assistance and Health Services (DMAHS) or the Department of Human Services (DHS) to adopt in any contract to provide HMO services to Medicaid recipients, its own process for appeals of utilization management determinations. At the request of the Commissioner of Human Services, the Commissioner shall adopt, in accordance with N.J.S.A. 52:14B-1 et seq. and N.J.A.C. 1:30, any such appeals process proposed by DMAHS or DHS as the exclusive appeals process for all Medicaid HMO members, if he or she find that it meets or exceeds the standards set forth in this chapter.

Amended by R.2000 d.183, effective May 1, 2000.

See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

In (b), substituted a reference to 60 days for a reference to 30 business days in the first sentence; in (c), rewrote the second sentence; and rewrote (i) and (k).

11:24-8.8 General requirements for independent utilization review organizations

(a) The Department shall, from time to time, enter into contracts with as many independent utilization review organizations as it deems necessary to conduct the external appeals provided for under N.J.A.C. 11:24-8.7. The physician re-