STATE OF NEW JERSEY
DEPARTMENT OF BANKING & INSURANCE

Governor Phil Murphy • Lt. Governor Tahesha Way

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IHCAP Vendor Change Notice

A contract for the independent utilization review organization to conduct external appeals under the IHCAP was recently awarded to a new vendor, Maximus Federal Services ("Maximus"). Under the contract, effective January 1, 2022, external appeal applications must be submitted directly to Maximus. More information is available in Bulletin No. 21-13.

If you have questions, please contact the Department via email at ihcap@dobi.nj.gov; or by telephone at 1-888-393-1062 or 609-777-9470.

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Independent Health Care Appeals Program

The **Independent Health Care Appeals Program** (IHCAP) is an external review program administered by the Department of Banking and Insurance (Department). The external review program is intended for the purpose of reviewing adverse utilization management determinations made by carriers (health plans) with respect to any health benefits plan for which the carrier uses utilization management features, whether prospective, concurrent, or retrospective.

The Department contracts through the State of New Jersey procurement process with Independent Utilization Review Organizations (IURO) to perform both the preliminary and full independent external reviews of adverse benefit determinations of health insurance carriers, including denials of requested services and/or reimbursement of services as not medically necessary, as experimental or investigational or as cosmetic. The right to an external review of your appeal is mandated by the New Jersey Health Care Quality Act, N.J.S.A. 26:2S-11 and 12. IURO review personnel and consultant specialty physicians are impartial and do not work for and are not affiliated with any New Jersey Health Carriers.

For more information...

Costs and Fees

The cost of reviews is fixed through the procurement process. Carriers bear the costs of both the preliminary and full review, and once a preliminary or full review is initiated, the carrier is responsible for the associated costs of that portion of the review, even if the carrier elects to reverse its own decision prior to the IURO rendering a decision on the matter, or the individual, or health care provider, as appropriate, elects to withdraw the appeal.

External Appeal Review Eligibility

Appeals under the IHCAP are not eligible for review if:

1. The individual is covered under a self-funded insurance plan, Medicare, or a Medicare Advantage product;
2. The individual is covered under a contract delivered in another state;
3. The services at issue were not covered under the terms of the health benefits plan;
4. When the appeal is submitted by a health care provider, the health care provider lacked consent of the covered individual to make the appeal; or
5. The internal appeal process has not been completed, unless the Carrier failed to meet the timeframes for the separate stages of appeal, waived its right to perform an internal review, or the individual and/or provider applied for an expedited external review at the same time as applying for an expedited internal review.

Preliminary Review Process:

Upon receipt of the appeal, the IURO will conduct a preliminary review, and accept the appeal for processing if the IURO determines the following:

1. The individual had coverage in effect under a health benefits plan at the time of the action on which the appeal is based;
2. The service that is the subject of the complaint or appeal reasonably appears to be a covered service under the terms of the contract at issue for purposes of the appeal;
3. The internal appeal process was appropriately completed, or approval to by-pass some portion of the process was received by the Department; and
4. The individual, or health care provider acting on behalf of the individual with the individual's consent, has provided all information required by the IURO and the Department to make the preliminary determination, including: the appeal form (or Medicaid version), a copy of any information provided by the carrier regarding the unfavorable utilization management determination, and a fully-executed release to obtain any necessary medical records from the carrier and any relevant health care provider. (The medical release is included in the Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims.)

Note: The IURO may consult with the individual or the health care provider, as appropriate, to try to obtain more information when reasonable or appropriate.

Preliminary Review Results:

For Standard External Appeal Requests:

The IURO will complete the preliminary review and notify the covered individual, representative and/or health care provider as appropriate, in writing of whether the appeal has been accepted for processing within five (5) business days of receipt of the request.

The IURO will also notify the covered individual, representative and/or health care provider of his or her right to submit in writing, within five (5) business days of the receipt of acceptance of the appeal, any additional

information to be considered in the IURO's review. Any additional information that is submitted will be shared with the covered person's Health Carrier.

For Expedited External Appeal Requests:

Upon receipt of a completed expedited appeal request, the IURO will complete the preliminary review and notify covered individual, representative and/or health care provider, as appropriate, in writing as soon as possible of whether the appeal has been accepted for expedited processing.

The IURO will also notify the covered individual, representative and/or health care provider of his or her right to submit in writing, by a specified time and date any additional information to be considered in the IURO's review. Any additional information that is submitted will be shared with the covered person's Health Carrier.

Important: Send only copies of any requested documents because originals WILL NOT be returned.

Full Review:

If an appeal is eligible for external review, the IURO will conduct a "full review" to determine whether an individual has been inappropriately denied medically necessary covered services by the carrier.

When performing the full review, the IURO relies on all information submitted by the parties to the matter that is deemed appropriate by the IURO, including:

- pertinent medical records including consulting physician reports,
- supporting documentation,
- any applicable, generally-accepted practice guidelines developed by the federal, government, and national or professional medical societies, boards and associations, and
- any applicable clinical protocols and/or practice guidelines developed or used by the carrier.

Additional Information*:*

What if the IURO needs additional information?

If the IURO determines that additional information would be beneficial for the full review process, a written request for additional information will be sent to the covered individual, representative and/or health care provider, as appropriate. This request will specify the additional information being requested and date by which such information must be submitted to be considered in the full review. Instructions will be provided for how to submit the additional information that is being requested. Any additional information that is submitted will be shared with the covered person's Health Carrier.

Important: Send only copies of any requested documents because originals WILL NOT be returned.

The Decision:

The IUROs use impartial consultant medical professionals to review cases. All decisions are approved by the IURO's medical director.

The IURO may uphold, reverse or modify the utilization management decision of the carrier. A modification means that the IURO upholds a portion of the carrier's utilization management decision and reverses a portion of it.

The IURO cannot recommend that services other than those at issue in the appeal be provided.

The written decision of the IURO, and the reasons for the decision, is sent to the covered individual, representative and/or health care provider, as appropriate, as well as to the carrier, and to the Department. The IURO's decision is binding on the covered individual and carrier, except to the extent that other remedies are available to either party under State or Federal law.

How long will it take for my External Appeal to be Decided?

The IURO will make a decision as soon as possible and this will not be more than 45 calendar days from when your request for an appeal was submitted.

What if I can’t wait that long?

You or your representative could request an expedited appeal. Expedited reviews are decided by the IURO within 48 hours from when the appeal request was submitted.

What qualifies as an Expedited External Appeal?

Expedited appeals are for urgent or emergent cases. An appeal can be expedited if:

- it involves a request for an admission to a health care facility;
- it involves a request for a continued stay after admission and you have not been discharged from the facility; or
- it involves a medical condition for which the standard review time frame would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

In order to qualify for an expedited review, you cannot have received all of the services being appealed.

How do I appeal?

You can file an external appeal electronically at **https://njihcap.maximus.com**

Persons who are unable to submit a request for an external appeal electronically can download the appeal form from the Maximus website above. Persons may also contact Maximus and ask that an appeal from be sent to them by regular mail and/or by fax.

What should I include with my appeal application?

The following documentation should be submitted with your appeal application:

- A copy of the Stage 1 and/or Stage 2 written decision(s) from the carrier. (*If you are covered by an individual health benefits plan or a Medicaid HMO, you will only have one written decision [Stage 1] from the carrier.)*
- A copy of the summary of coverage from your member handbook, certificate of coverage or other evidence of coverage issued by your carrier.
- If a health care provider filing on behalf of a member, a copy of the member's consent to have an appeal of the adverse utilization management decision made on his or her behalf. Whenever possible, please use Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims.
- A copy of all medical records and correspondence to be reviewed by the Independent Health Care Appeals Program.

You can also submit any other information you feel would be helpful for the IURO to have when it reviews your appeal. Please note that any information that is submitted for the appeal will be shared with the covered person’s Health Carrier.

How do I submit my appeal?

You can complete your application and submit all required documents online at **https://njihcap.maximus.com**

If unable to apply electronically, the completed appeal form can be returned to Maximus by fax or mail as set forth below.

Fax: 585-425-5296
Mail: Maximus Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705

Pittsford, NY 14534

Questions about the application process can be directed to Maximus Federal by calling **888-866-6205** or e-mailing **Stateappealseast@maximus.com**.

Important: Send only copies of any requested documents because originals WILL NOT be returned.

Confidentiality

The information related to, and the outcome of, any specific case is confidential, and is not subject to release by the IURO or the Department. However, the Department does produce a semi-annual report regarding the activities of the IHCAP for a six-month period, typically ending in February and August.

Semi-Annual Reports

The Independent Health Care Appeals Reports, generated for the Legislature and Governor, are posted as they become available for release. The information contained in the semi-annual reports never identifies any individual or any details about any specific case. The information is presented in the aggregate, and provides information about the number of appeals processed, and the number of appeals upheld and reversed.

OPRA is a state law that was enacted to give the public greater access to government records maintained by public agencies in New Jersey.

You will need to download the latest version of Adobe Acrobat Reader in order to correctly view and print PDF (Portable Document Format) files from this web site.

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