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Date: Feburuary 14, 2017
Re: New NJ PIP Regulation – NJAC 11:3-4.7B Uniform Internal Appeal Process
Effective Date: April 17,2017

Per DOBI: "The Department believes that the rule should apply to pre-service and post-service appeals that are submitted on or after April 17, 2017. This would result in all appeals.

Summary:

- New administrative rule NJAC 11:3-4.7B goes becomes operational on 4/17/17 (*See the attached for the actual text of the administrative rule*).

- **An Arbitration CANNOT BE FILED without completing the internal appeal process.** We anticipate that *Forthright* will be creating its own rule asking for internal appeals prior to filing arbitration demands.

- The insurance carriers will be issuing new Decision Point Revie Plan ("DPRP") which you must review to ensure you have the proper fax numbers and understand each carriers specific requirement.

- Appeals can only be done using the attached uniform DOBI forms.

- The central rule is that each issue shall only be required to receive one internal appeal review by the insurer prior to arbitration.

- There will be two types
  A. **Pre- Service Appeal:** dealing with appeals of DPRP and/or pre-certification denials or modifications before performing or issuing the service or providing the durable medical equipment.
     - It must be submitted **no later than 30 days after receipt of the denial** or modification of the requested service
     - The **issuer has 14 days after the receipt of the pre-service appeal to respond**.

B. **Post-Service Appeal**: for appeals after the performance or issuing the services.
   - **MUST be submitted at least 45 days prior to initiating arbitration or filing an action** in Superior Court.
   - The insurer has **30 days from the receipt of the post service appeal to respond**.

- **Key:** Please make sure ALL your appeals include supporting documentation. We anticipate the insurers will be attacking the sufficiency of documentation submitted during the internal appeal phase. Thus, we would like all providers to submit ALL treatment records that support your position on the specific issue being appealed along with a brief explanation letter to the carrier.

General questions:

- What is the consequence for an Insurer not responding to a pre-service appeal? According to DOBI Comments: Nothing but leaves room at arbitration for objection to the carrier raising the appealed issue as a defense.

  DOBI response: The Department believes, and has repeatedly stated, that the internal appeal process is the venue where the issue being appealed should be addressed fully. Although there is no specific provision for it in the rule, at arbitration, the claimant can still object to the defenses raised by an insurer when the insurer can be shown to have failed to respond to the internal appeal. The Dispute Resolution Professional's decision should specifically address whether such documentation or information should be considered.

- What happens if you miss the appeal deadline? Similarly to the above, nothing, however, the insurer can raise failure to submit timely as an issue at arbitration. Nothing bars you from remedying a missed timeline. If you miss the deadline submit an appeal anyways.

  COMMENT: One commenter questioned if there are any extensions or means to request a new decision point review/pre-certification as was originally proposed by the Department, and, if not, what was the basis for eliminating it in instances where a provider misses a deadline for time to appeal. The commenter stated that a busy practice may miss a deadline and there should be an ability to request the treatment plan or seek a post-service appeal prior to filing arbitration rather than simply void a valid assignment of benefits and require the patient consumer to proceed with attempting to get the services properly paid.
  DOBI RESPONSE: The Department does not agree with the commenter that the rule does not permit a provider to submit another decision point review request if an appeal deadline is missed. The rule is silent on any consequences to providers for failure to submit a timely appeal. Therefore, a provider is free to submit another decision point review request when an appeal deadline has been missed.

- When should I send my file for arbitration? Immediately after I do my post-service appeal as our office will not file until the 30 day response passes.

If you need our assistance on implementation and understanding this rule, please do not hesitate to email our office at ao@melvinmarx.com or pipcase@melvinmarx.com.

Very yours truly,
Adebukola Ogunsanya
For the Firm

NJAC 11:3-4.7B Requirements for insurer internal appeals procedures

(a) The internal appeal procedure in an insurer's Decision Point Review Plan (DPR Plan) shall meet the requirements m this section.

(b) Insurers shall only require a one-level appeal procedure for each appealed issue before arbitration. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to arbitration. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and for durable medical equipment on the grounds of medical necessity 1s a different issue than an appeal of what the insurer should reimburse the provider for that same service.

(c)All appeals shall be initiated using the forms established by the Department by Order in accordance with N.J.A.C.11:3-4.7(d) and posted on the Department's website.

(d)The appeal forms and any supporting documentation shall be submitted by the provider to the address and/or fax number designated for appeals in the insurer's DPR Plan. Pursuant to N.J.A.C. 1 l: 1-4 7, insurers may permit electronic filing of appeals by providing the process for electronic filing in its DPR Plan.

(e) There shall be two types of internal appeals:

l. Pre-service: Appeals of decision point review and or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services"); and

2. Post-service: Appeals subsequent to the performance or issuance of the services.

(f} A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

(g) A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N .J .A.C. 11:3-5 or filing an action in Superior Court.

(h)Decisions on pre-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation.

(i)Decisions on post-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation.

(j) Nothing in this section shall be construed so as to require reimbursement of services that are not medically necessary or to prevent the application of the penalty co-payments in N.J.A.C. 11:3-4.4(e).

NEW JERSEY PIP PRE-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	**11. CITY**	**12. STATE**	**13. ZIP**

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME
17. SPECIALTY	**18. TAX ID #**	**19. NPI #**

20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ ***ORIGINAL APTP FORM**
- ☐ ***APTP DECISION/RESPONSE DOCUMENT**
- ☐ ***APPEAL RATIONALE NARRATIVE**
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ DIAGNOSTIC REPORT(S)
- ☐ PEER REVIEW REPORT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe): _____

PRE-SERVICE APPEAL ISSUES

30. DATE(**S**) OF REQUEST **F**ROM → **T**O						31. CPT, HCPCS, NDC	32. RESPONSE NOT RECEIVED WITHIN 3 BUSINESS DAYS YES INDICATE WITH **X**	33. ADMINISTRATIVE DISPUTE YES INDICATE WITH **X**	34. MEDICAL NECESSITY DISPUTE YES INDICATE WITH **X**
MM	DD	YY	MM	DD	YY				

*** Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only**

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

35. SIGNATURE OF PROVIDER _____ 36. DATE _____

NEW JERSEY PIP POST-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH

10. ADDRESS (No. Street)	11. CITY	12. STATE	13. ZIP

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME

17. SPECIALTY	18. TAX ID #	19. NPI #

20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ ***ORIGINAL BILL (HCFA/UB)**
- ☐ ***EXPLANATION OF BENEFIT/PAYMENT**
- ☐ ***APPEAL RATIONALE NARRATIVE**
- ☐ APTP DECISION/RESPONSE
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ PEER REVIEW REPORT
- ☐ AUDIT REPORT
- ☐ NETWORK TERMINATION DOCUMENT
- ☐ PPO CONTRACT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe): _____

POST-SERVICE APPEAL ISSUES

30. EOB ID	31. TOTAL BILL REIMBURSEMENT	32. EXPECTED BILL REIMBURSEMENT	33. **BILL LEVEL APPEAL CODE(S) 1-10

34. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S

*** Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only**

**** Indicates sections that should be completed using the letter(s)/number(s) that correspond to the reason codes on the back of this form**

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PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39. SIGNATURE OF PROVIDER _____ 40. DATE _____

NEW JERSEY PIP POST-SERVICE APPEAL
REASON CODES

	BILL LEVEL APPEAL CODES		LINE LEVEL APPEAL CODES
1	Improper Deductible Applied	A	Improper Application of Fee Schedule Amount
2	Improper Co-pay Applied	B	Improper Application of Modifier Reduction
3	Improper Interest Applied	C	Improper Application of Multiple Reduction Calculation
4	Interest Due - Payment Not Made Timely	D	Improper Application of Daily Max Cap Calculation
5	Bill Processed Under Wrong Patient	E	Improper use of National Correct Coding (NCCI)
6	No Response To Bill Submitted Post 60 Days	F	Improper Application of U&C Amount
7	Improper Application of Coordination of Benefits	G	Improper Application of PPO Amount
8	Improper Use of PPO - Not Participating In Network	H	Improper Application of Pre-cert Penalty Co-pay
9	Improper Use of PPO - Terminated From Network	I	Improper Application of Voluntary Network Penalty Co-pay
10	Improper Denial Based on Coverage Investigation	J	Improper Application of Prospective Medical Necessity Denial
		K	Improper Application of Retrospective Medical Necessity Denial
		L	Improper Application of Bill Audit Reduction
		M	Improper Application of Medical Code Review Reduction
		N	Improper Application of Peer Review Reduction
		O	Improper Application of IME Reduction
		P	Improper Application of Missing Supportive Medical Records Denial
		Q	Improper Application of Coordination of Benefits
		R	Data Capture Error Caused Improper Reimbursement
		S	No Response to Services Billed