Policy: **Provider and Practitioner Appeals and Grievances – New Jersey**

Date of Implementation: **July 9, 2003**

Product: **Specialty**

American Specialty Health – Specialty (ASH) is committed to promoting effective health care and recognizes that providers and practitioners have a right to file appeals and grievances. This policy describes the provider and practitioner appeal and grievance processes established by ASH.

Provided that ASH is delegated to handle claims payment and/or medical necessity (utilization management) appeals, a practitioner may appeal any non-payment of a claim or any Medical Necessity/Benefit Determination.

The procedures that practitioners will follow when appeals are not delegated to ASH are set forth in the applicable Practitioner Services Agreement.

Definitions:

Appeal -

Coverage Dispute/Administrative - Any appeal resulting from an adverse benefit determination unrelated to medical necessity.

Medical Necessity - Any appeal resulting from the adverse benefit determination of treatment/services relative to medical necessity.

Medical Necessity Expedited - An appeal that is resolved expeditiously if the member's health or ability to function could be seriously harmed by waiting for a determination to be made under the normal Medical Necessity Appeal Timeframe, or the practitioner indicates there is an urgent need for continued care.

Grievance - A formal expression of dissatisfaction where ASH is not being requested to review or overturn an ASH decision.

Adverse Benefit Determination – A declination (which includes a denial, reduction, or termination of, or a failure to make partial or whole payment) for a benefit, including any such declination for that plan.

Additionally, with respect to group health plans, a declination for a benefit resulting from the application of any medical necessity review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If a provider or practitioner files an appeal on behalf of a member with the member's written consent, the appeal process defined in the ASH *Member Appeals and Grievances – New Jersey (NJ UM 4 – S)* policy will be followed.

Effect of Filing an Appeal or Grievance

ASH will take no retaliatory actions against the provider or practitioner as a result of filing an appeal or grievance.

I. PROVIDER AND PRACTITIONER APPEALS

Medical Necessity Appeals

Overview

ASH provides reasonable opportunity to providers and practitioners for a full and fair review of an adverse benefit determination by offering two (2) stages of appeal.

At each stage of appeal, providers and practitioners are given the opportunity to submit for review written comments, documents, records, and other information relating to their appeal request. ASH documents if a practitioner does not submit information related to the appeal within the submission timeframe. This documentation, received by ASH in support of the appeal, is reviewed as a component of the appeal, whether or not such documentation was considered at the time of the initial determination.

When making an appeal decision of an adverse benefit determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, ASH will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment.

Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the appeal determination process. In addition, a health care professional engaged in the appeal process for purposes of a consultation will be an individual who was not consulted in connection with the adverse benefit determination or the subordinate of any such individual.

If a provider or practitioner submits an appeal for services the member has already appealed, the provider or practitioner request will be dismissed and the member request

will be processed. If the provider or practitioner has appealed, the member can still appeal but not vice versa, unless a provider or practitioner provides significant additional information supporting the medical necessity that was not available at the time of the member's appeal.

In the event that the practitioner initiates an appeal, the practitioner must notify the member. The practitioner provides additional notice to the member each time he/she continues the appeal to the next stage in the appeal process, including any appeal to an Independent Utilization Review Organization (IURO).

During the review of an appeal, the reviewers will not give deference to the initial adverse determination when making their appeal determinations.

ASH would continue to provide coverage and make payment for the currently approved ongoing course of treatment while an internal appeal is under review.

Submission Timelines

If a provider or practitioner disagrees with an initial adverse benefit determination, he/she may appeal within 180 days of the date of the adverse benefit determination notification letter. Appeals may be submitted in writing, verbally, or on-line at www.ashlink.com.

Resolution and Notification Timelines

ASH resolves the first stage of a standard appeal within ten (10) calendar days from the receipt of the appeal. ASH resolves the second stage of a standard appeal within 20 business days from the receipt of the appeal.

In the case that a first or second stage appeal decision overturns the initial adverse benefit determination, ASH will implement the decision.

The period of time within which an appeal determination is required to be made begins at the time an appeal is filed with ASH. ASH makes decisions on appeals based on all information provided by the provider or practitioner within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the provider or practitioner appeal is maintained, including the complete investigation of the substance of the appeal and any aspects of clinical care involved.

Reviewers

1st Stage: ASH's medical director or his/her designee reviews the appeal.

ASH will provide an opportunity for the Member to speak to ASH's medical director or his/her designee who rendered the adverse benefit determination regarding an adverse service or benefits determination.

2nd Stage: A panel of practitioners including at least one (1) New Jersey licensed physician selected by ASH who have not been involved in the adverse benefit determination at issue. The Member has the right to be present to pursue his/her appeal before the panel. The decision made by the panel is the final decision at this stage.

ASH will allow a contracted practitioner in the same/similar specialty of the treating practitioner to participate with the panel in the review of the case if so requested by the Member.

In all cases, licensed physicians (MD/DO) adhere to established clinical criteria when reviewing appeals.

Physicians (MD/DO) and clinical quality evaluators are board certified, if applicable, by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. Clinical quality evaluators maintain an active, unrestricted license, certificate, or registration in their specialty in a state or territory of the United States. Unless expressly allowed by state or federal laws or regulations, clinical quality evaluators are located in a state or territory of the United States when reviewing an appeal.

For each appeal, the reviewer will attest that he/she has the appropriate licensure/certification/registration that typically manages the treatment/services under review and the experience and knowledge to conduct the appeal review.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the provider or practitioner. The notification letter includes the following information:

- Resolution of the issue;
- List of titles, qualifications and the specialty of participants in the appeal review;
- A clear and concise explanation in culturally and linguistically appropriate language of reasons for determination;
- Clinical rationale associated with the decision including the following:
  - The internal rule guideline, protocol, benefit provision or other similar criterion relied upon in making the determination; or
  - A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the practitioner, upon request and free

of charge by contacting the Customer Service Department at (800) 972-4226 or on-line at www.ashlink.com; and
- Notification that the provider or practitioner is entitled to receive, upon request and free of charge, reasonable access to and copies of documents relevant to the appeal.

Notification of an adverse appeal decision will also include the following:
- An explanation of the scientific or clinical judgment for the determination, applying the terms of ASH to the medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation.
- A description of the provider or practitioner's further appeal rights including notification that the provider or practitioner is given 45 calendar days to submit to the next level of appeal, if applicable.

Independent Review
If the provider or practitioner is not satisfied with the determination after the internal stages of appeal are completed, the provider or practitioner has the option to pursue an independent external review in accordance with the guidelines describe in the Independent Stages of Review, Medical Necessity Appeals section of this policy.

Medical Necessity Expedited Appeals
Overview
ASH provides reasonable opportunity to providers and practitioners for a full and fair review of a pre-service adverse benefit determination by offering two (2) stages of review for expedited appeals.

Providers and practitioners are given the opportunity to submit written comments, documents, records, and other information relating to their appeal request. ASH documents if a practitioner does not submit information related to the appeal within the submission timeframe. This documentation, received in support of the appeal, will be reviewed as part of the appeal, whether or not such documentation was considered at the time of the initial determination. A post-service appeal is not handled as an expedited appeal and will be handled within the timelines established in the Provider and Practitioner Medical Necessity Appeals section of this policy.

When making an appeal decision of an adverse benefit determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, ASH will consult with a healthcare professional that has appropriate training and experience in the field of medicine involved in the medical judgment.

Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the appeal determination process. In addition, a health care professional engaged in the appeal process for purposes of a consultation will be an individual who was not consulted in connection with the adverse benefit determination or the subordinate of any such individual.

During the review of an appeal, the reviewers will not give deference to the initial adverse determination when making their appeal determinations.

ASH would continue to provide coverage and make payment for the currently approved ongoing course of treatment while an internal appeal is under review.

Submission Timelines

A provider or practitioner may submit written or verbal appeals within a reasonable timeframe as warranted by the urgency of the member's condition. ASH will initiate an expedited pre-service appeal when requested by the provider or practitioner.

Resolution and Notification Timelines

ASH resolves and notifies the provider or practitioner verbally of the determination at each stage of appeal as soon as possible, but no later than 72 hours from the receipt of the appeal. Written confirmation of the notification is provided to the provider or practitioner within three (3) calendar days from the receipt of the appeal.

The period of time within which an appeal determination is required to be made begins at the time an appeal is filed. ASH makes decisions on appeals based on all information provided by the provider or practitioner within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the provider or practitioner appeal is maintained, including the complete investigation of the substance of the appeal and any aspects of clinical care involved.

Reviewers

1st Stage: ASH's medical director or his/her designee reviews the appeal.

ASH will provide an opportunity for the Member to speak to ASH's medical director or his/her designee who rendered the adverse benefit determination regarding an adverse service or benefits determination.

2nd Stage: A panel of practitioners including at least one (1) New Jersey licensed physician selected by ASH who have not been involved in the adverse benefit determination at issue. The Member has the right to be present to pursue his/her appeal before the panel. The decision made by the panel is the final decision at this stage.

ASH will allow a contracted practitioner in the same/similar specialty of the treating practitioner to participate with the panel in the review of the case if so requested by the Member.

In all cases, licensed physicians (MD/DO) adhere to established clinical criteria when reviewing appeals.

Physicians (MD/DO) and clinical quality evaluators are board certified, if applicable, by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. Clinical quality evaluators maintain an active, unrestricted license, certificate, or registration in their specialty in a state or territory of the United States. Unless expressly allowed by state or federal laws or regulations, clinical quality evaluators are located in a state or territory of the United States when reviewing an appeal.

For each appeal, the reviewer will attest that he/she has the appropriate licensure/certification/registration that typically manages the treatment/services under review and the experience and knowledge to conduct the appeal review.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the provider or practitioner. The notification letter includes the following information:

- Resolution of the issue;
- List of titles, qualifications and the specialty of participants in the appeal review;
- A clear and concise explanation in culturally and linguistically appropriate language of reasons for determination;
- Clinical rationale associated with the decision including the following:
  - The internal rule guideline, protocol, benefit provision or other similar criterion relied upon in making the determination; or
  - A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the practitioner, upon request and free of charge by contacting the Customer Service Department at (800) 972-4226 or on-line at www.ashlink.com; and
- Notification that the provider or practitioner is entitled to receive, upon request and free of charge, reasonable access to and copies of documents relevant to the appeal.

Notification of an adverse appeal decision will also include the following:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of ASH to the medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation; and

- A description of the practitioner's further appeal rights.

Independent Review
If the provider or practitioner is not satisfied with the determination after the internal stage of appeal is completed, the provider or practitioner has the option to pursue an independent stage of appeal. Additional information regarding the practitioner's independent levels of review is available in the Independent Stage of Review, Medical Necessity Appeals section of this policy.

II. INDEPENDENT STAGES OF REVIEW

Medical Necessity Appeals

Overview
If a provider or practitioner files an appeal on behalf of a member with the member's written consent, the appeal process defined in the ASH *Member Appeals and Grievances – New Jersey (NJ UM 4 – S)* policy will be followed.

ASH provides providers and practitioners with the option to pursue one (1) voluntary stage of appeal, either independent review or arbitration.

Independent Review Process
The provider or practitioner may request an independent review by contacting ASH. If the provider or practitioner chooses to pursue a review through an Independent Review Organization (IRO), there is a $50 charge and the decision of the IRO is binding.

Arbitration
The provider or practitioner may initiate arbitration through the American Arbitration Association (the Association). To initiate the arbitration process, the practitioner may contact the Association at (877) 495-4185. The Association arbitration determination is binding.

III. PRACTITIONER APPEALS
Payment or Denial of a Claim

Submission Timelines
Practitioners may initiate an appeal on or before the 90th calendar day following receipt by the practitioner of ASH's claims determination (or by the Health Plan in the case that ASH is not delegated to pay claims), which is the basis of the appeal, by submitting a fully completed DOBI form (available at https://www.state.nj.us/dobi/chap352/352genapplication.doc) together with all information and documentation requested by such form. If the practitioner does not file an appeal by submitting the Health Care Provider Application to Appeal a Claim

Determination form to ASH within 90 days after the date of the determination of a claim, such appeal will not be considered by ASH. The member will not be billed for any charges for covered services not approved for payment due to late submission of the Health Care Provider Application to Appeal a Claim Determination form by the practitioner, and all such charges will be waived by the practitioner.

Reviewers

A claims payment appeal is reviewed by ASH management staff not responsible for claims payment on a day-to-day basis, and is provided at no cost to the practitioner.

Timelines and Notification of Appeal Resolution

A claims payment appeal is reviewed, and a written notification of the appeal decision is sent to the practitioner within 30 calendar days of receipt of the appeal. The notification of the appeal decision includes:

- The names, titles, and qualifying credentials of the persons participating in the review;
- A re-statement of ASH's understanding of the practitioner's appeal;
- The decision of the reviewers and a detailed explanation of the basis for such decision;
- A description of the evidence or documentation that supports the decision; and
- A description of how to request Arbitration if the final internal appeal decision by ASH results in an adverse benefit determination.

ASH will conduct a review of the appeal and notify the practitioner of its determination on or before the 30 calendar day following ASH's receipt of the completed appeal form.

If the practitioner is not notified of ASH's determination of the appeal within 30 days, the practitioner may refer the dispute to arbitration.

If ASH determines through the internal appeal process that the practitioner's claim should be paid, ASH shall pay such claims with accrued interest at the rate of 12% per annum, on or before the 30th calendar day following the notification of ASH's determination on the appeal.

Interest will begin to accrue on the day the appeal was received by ASH.

Program for Independent Claims Payment Arbitration

Either the practitioner (if they are not satisfied with the determination after the internal stage of appeal is completed) or ASH may initiate an arbitration proceeding on or before the 90th calenda day following receipt of the determination which is the basis of the appeal, by submitting the DOBI form and all required information and documentation for

submission of a claim to the Program for Independent Claims Payment Arbitration (PIPCA).

The State of New Jersey defines arbitration as any dispute regarding the determination of an internal health plan appeal, not including medical necessity appeals. The practitioner may initiate arbitration on or before the 90th calendar day following receipt of the initial health plan claim determination which is the basis of the appeal, on a form prescribed by the New Jersey Commissioner of Banking and Insurance. No dispute will be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that the practitioner may aggregate disputed claim amounts for the purpose of meeting the threshold requirements.

To initiate arbitration, a practitioner is required to complete an application, accessible online at https://njpicpa.maximus.com/, and submit the application with the required review and arbitration fees. Applications are submitted online. A case number is generated through the online submission process. If a practitioner wishes to submit their application by mail, they must contact the arbitration company using the contact information at https://njpicpa.maximus.com/.

Supporting documentation may be submitted online, via fax or mail and must include the case number. Fees must be submitted by mail and include the case number. An application for arbitration will not be considered until the required application fees are received.

Both a practitioner requesting arbitration and ASH are required to pay a review fee and an arbitration fee. A practitioner must submit his/her fees with the arbitration application. If the application initially meets the criteria for acceptance, the arbitration organization will notify ASH of the action and of the fee requirements. If based on information received by ASH the arbitration company ultimately determines that the case does not meet the criteria for arbitration, the arbitration organization will return the arbitration fees to both parties but will retain the review fees.

For a single claim in which the dispute is at least $1,000, the arbitration organization requires each party to pay a $50 review fee and a $130 arbitration fee. For aggregated claims in which the disputed amount for each individual claims is less than $1,000, an additional $50 review fee and $130 arbitration fee will be assessed for every $1,000 worth of disputed claim amounts. For aggregated claims in which the disputed amount for each individual claims exceeds $1,000, fees will be assessed based on the number of individual claims rather than their dollar amount (e.g., five aggregated claims would be assessed five review and five arbitration fees).

The arbitrator conducts the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or Federal law.

An arbitrator's determination will be:

- Signed by the arbitrator;
- Issued in writing on a form prescribed by the Commissioner of Banking and Insurance, and will include a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
- Issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitrator will resolve the dispute within 30 calendar days of receiving all necessary information from the practitioner.

If an arbitrator determines that ASH has wrongfully withheld or denied payment, ASH will pay the claim, together with accrued interest at 12% per annum (if ordered by the arbitrator), calculated from the date that ASH's payment was due (the date 30 days following electronic submission of the claim, or 40 days following a paper submission) on or before the 10th business day following the issuance of the determination.

The arbitration determination cannot be appealed and will be binding on all parties to the dispute.

If the arbitrator determines that ASH has withheld or denied payment in violation of the provisions of Sections NJSA 26:2J-8.1 or NJSA 17B:27-44.2, the arbitrator will order ASH to make payment of the claims, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that ASH has withheld or denied payment on the basis of information submitted by the practitioner and ASH requested but did not receive this information from the practitioner when the claim was initially processed or reviewed under internal appeal pursuant to the provisions of Sections NJSA 26:2J-8.1 or NJSA 17B:27-44.2, ASH will not be required to pay any accrued interest.

If the arbitrator determines that a practitioner has engaged in a pattern and practice of improper billing and a refund is due to ASH, the arbitrator may award ASH a refund including accrued interest.

The arbitrator will file a copy of each determination with and in the form prescribed by the New Jersey Commissioner of Banking and Insurance.

IV. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS
Not related to Payment or Denial of a Claim

Overview

ASH provides reasonable opportunity to providers or practitioners for a full and fair review of an adverse benefit determination by offering three (3) stages of appeal. At each stage of appeal, provider or practitioners are given the opportunity to submit for review written comments, documents, records, and other information relating to their appeal request. This documentation, received by ASH in support of the appeal, is reviewed as a component of the appeal, whether or not such documentation was considered at the time of the initial determination.

Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the appeal determination process.

Submission Timelines

If a provider or practitioner disagrees with an initial adverse determination, he/she may appeal within 180 days of the date of the adverse benefit determination notification letter. Appeals may be submitted in writing, verbally, or on-line at www.ashlink.com.

Resolution and Notification Timelines

ASH resolves and notifies the provider or practitioner of each stage of an administrative appeal within 30 calendar days from the receipt of the appeal.

The period of time within which an appeal determination is required to be made begins at the time an appeal is filed with ASH. ASH makes decisions on appeals based on all information provided by the provider or practitioner within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the provider or practitioner appeal is maintained, including the complete investigation of the substance of the appeal and any aspects of clinical care involved.

Reviewers

1st Stage: A minimum of two (2) operational managers reviews the appeal and makes an appeal determination.
2nd Stage: The Administrative Review Committee (ARC) reviews the appeal and makes an appeal determination.
3rd Stage: The Executive Review Committee (ERC) reviews the appeal and makes an appeal determination. The appeal decision made by the ERC is the final decision at this appeal level.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the provider or practitioner. The notification letter includes the following information:

- Resolution of the issue;
- List of titles, qualifications and the specialty of participants in the appeal review; and
- Notification that the provider or practitioner is entitled to receive, upon request, reasonable access to and copies of documents relevant to the appeal.

Notification of an adverse appeal decision will also include the following:

- A clear and concise explanation in easily understandable language of reasons for the determination;
- Rationale associated with the decision including the following:
  - The internal rule guideline, protocol, benefit provision or other similar criterion relied upon in making the determination; or
- A description of the provider or practitioner's further appeal rights which includes arbitration, if applicable.

Arbitration

The provider or practitioner may initiate arbitration through the American Arbitration Association (the Association). To initiate the arbitration process, the provider or practitioner may contact the Association at (877) 495-4185. The Association arbitration determination is binding.

V. PROVIDER AND PRACTITIONER GRIEVANCES

Overview

ASH provides providers and practitioners with the opportunity to submit a grievance if they are dissatisfied with ASH policies, procedures, or service. ASH offers one (1) grievance stage.

Submission Timeline

A provider or practitioner may submit a formal verbal or written grievance to ASH at any time.

Resolution Timeline

Grievances are resolved within 30 calendar days from the receipt of the grievance.

Reviewers

The Appeals and Grievances Department researches and reviews the case, and if applicable, contacts the provider or practitioner in an effort to resolve the grievance.

Notification of Grievance Resolution

After a determination is made regarding the grievance, a resolution letter is sent to the provider or practitioner. The notification letter includes the following information:

- A summary of the grievance;
- Resolution of each issue, including a clear and concise explanation of reasons for determination; and
- Notification that the provider or practitioner may have a right to file their grievance in accordance with their state's grievance procedures, if available.