Table of contents

Member or Provider on behalf of Member appeals process

There are two broad types of appeals available to Members for which providers may submit on behalf of a Member, with the Member's consent — utilization management and administrative. Utilization management appeals relate to denials based on Medical Necessity, medical appropriateness, or clinical issues. Administrative appeals relate to denials or disputes regarding nonmedical administrative issues, benefits limits, or other contractual terms of the health plan.

Appeals can be pre-service or post-service. Standards for appeal time frames and processes are established by applicable State and federal laws, as well as national accrediting organization guidelines adopted by AmeriHealth New Jersey. Appeals procedures are subject to change.

Utilization management appeals and administrative appeals are addressed in detail within this section.

Note: The process for self-insured groups, government-sponsored plans, and certain other plans can vary from what is described on the following pages, and the guidelines are not described in this document. The availability of further appeal review through the plan administrator varies. Therefore, you should contact the Member's plan administrator, consult the *Member Handbook*, or Customer Service for information on the appeals process for a self-insured group.

Internal utilization management appeals

AmeriHealth Insurance Company of New Jersey and AmeriHealth HMO, Inc. (collectively, AmeriHealth New Jersey) maintain an internal utilization management appeals process for any Member who is dissatisfied with any AmeriHealth New Jersey utilization management coverage decision. The utilization management appeals process provides the Member the opportunity to discuss the decision with an AmeriHealth New Jersey Medical Director/peer reviewer and appeal the adverse benefits determination.

A utilization management coverage decision is defined as any decision to deny, terminate, or limit the provision of covered health care services that is based primarily on Medical Necessity or appropriateness. Each internal appeal stage will be completed within the applicable time frames described on the following pages.

Member representatives

A Provider or another individual may appeal on behalf of the Member as the Member's authorized representative ("Member designee") if a valid consent or authorization *form* from the Member is provided to AmeriHealth New Jersey. However, in expedited or urgent care appeals, a valid Member consent or authorization form is not required if a health care professional with knowledge of the Member's medical condition (e.g., a treating Provider) acts as the Member's authorized representative. Also, we have staff members available to assist and/or represent Members in the appeals process.

Commercial Member appeals filed by Providers must be filed within 180 days of receipt of a decision from AmeriHealth New Jersey stating an adverse benefits determination. AmeriHealth New Jersey will not accept Provider-on-behalf-of-Member appeal requests that are submitted after the Member appeal filing deadline.

Appeal classifications

Appeals of utilization management coverage decisions are also sometimes called pre-service appeals or post-service appeals. A pre-service appeal is for benefits that are only covered if

Pre-approved/Pre-certified before medical care is obtained; all other appeals are post-service. Utilization management appeals are usually considered pre-service appeals.

Matched specialist review

Decision makers for utilization management appeals are matched specialists — licensed Physicians, psychologists, or other health care professionals in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefits determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Information for the appeal

At each appeal stage, all information gathered for the appeal will be considered by the decision-makers. This consists of information obtained from our investigation, as well as any additional information submitted by the Member or Member designee. Upon request at any time during the appeal process, we will provide the Member or Member designee a copy of the correspondence, documents, medical records, and other information provided to the decision-makers for internal appeal. We may delete from the copy provided to a Member or Member designee certain information that we consider confidential and/or proprietary.

Full and fair review

The Member or Member designee is entitled to a full and fair review. Specifically, at all appeal levels the Member or Member designee may submit additional information pertaining to the case, to AmeriHealth New Jersey. The Member or Member designee may specify the remedy or corrective action being sought. At the Member's request, AmeriHealth New Jersey will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. AmeriHealth New Jersey will automatically provide the Member or Member designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal that is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or Member designee at no charge.

Appeal stages

As described on the following pages, the Member or Member designee has a maximum of three opportunities to appeal a utilization management coverage decision. There are two internal levels of appeal conducted by AmeriHealth New Jersey: stage I and stage II. After the internal appeals are completed, the Member or Member designee may request an external review to the extent mandated by the State of New Jersey or as determined by other applicable authorities (see "*External reviews*").

Urgent/expedited care

An urgent/expedited appeal is any appeal for medical care or treatment in which the application of the time periods for making nonurgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

Stage I appeals (internal)

A Member, Provider, or Member designee may initiate a stage I appeal with an AmeriHealth New Jersey Medical Director/peer reviewer by calling or writing to the AmeriHealth New Jersey Appeals Unit, as outlined in the initial AmeriHealth New Jersey denial letter, or by calling Customer Service at the telephone number listed on the Member's AmeriHealth New Jersey ID card. The appeal must be filed within 180 days of receipt of the initial utilization management determination letter.

A stage I appeal consists of an opportunity for a discussion and/or review of a utilization management coverage decision based on review of available information. Within the time periods that apply to the stage I appeal review (see below), an AmeriHealth New Jersey Medical Director or Provider designee will conduct a review and a decision will be issued. An AmeriHealth New Jersey Medical Director or Provider designee who has not been previously involved in the decision-making on the case, and who is not a subordinate of the decision-maker, will be the decision-maker for each stage I appeal — whether it is expedited or non-expedited.

Non-expedited stage I appeals

Non-expedited (or standard) stage I appeals will be completed and a decision letter providing written notice of the decision with an explanation of the appeal rights, as appropriate, will be sent within ten calendar days of our receipt of the original appeal request.

Expedited stage I appeals

The stage I appeal will be processed as an expedited or urgent care appeal whenever the Member is confined in an inpatient facility, upon the request of the Member's Provider, and/or when we determine that a delay in decision-making based on non-expedited appeal time frames could seriously jeopardize the Member's life, health, or ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed while awaiting a non-expedited appeal decision. Expedited appeal review will be completed within 72 hours after our receipt of the appeal, with approximately 24 hours allotted to the stage I expedited appeal and approximately 48 hours to the stage II expedited appeal.

The Member, Member designee, and other Providers, as appropriate, will be notified of the AmeriHealth New Jersey Medical Director's decision on the stage I expedited appeal verbally or by fax within 24 hours after receipt of the expedited appeal. At that time, we will also provide notice of the opportunity to go forward with a stage II expedited appeal. The letter with written confirmation of the expedited stage I decision will include an explanation of appeal rights, as appropriate. That decision letter will be sent to the Member, Member designee, and other Providers, as appropriate, within 24 hours after receipt of the original expedited appeal request.

Stage II appeals (internal)

Stage II appeals are offered only to Members in a group plan. If the Member is dissatisfied with the outcome of the stage I appeal, the Member or Member designee may file a stage II appeal by calling or writing to us within 180 days of receipt of the stage I decision letter. Directions for filing a written or verbal stage II appeal are outlined in the stage I decision letter.

Stage II appeals are presented to a panel of Providers and/or other health care professionals who have not been previously involved in the decision-making on the case and who are not subordinates of those previously involved. The Member or Member designee may appear before the panel or participate by conference call or other appropriate technology.

The Member may also ask us to appoint a staff member who has no direct involvement with the case to represent him or her before the panel. The stage II appeal panel will review available information. If requested by the Member or Member designee, we will arrange for a consultant provider (a matched specialist with no prior involvement in the case) to be available to participate in the panel's review of the case.

Non-expedited stage II appeals

For non-expedited (or standard) stage II appeals, we will send an acknowledgment letter upon receipt of the stage II appeal request. The stage II appeal will be completed with review by an appeal panel, as described above, and a decision letter providing written notice of the stage II decision and an explanation of appeal rights, as appropriate, will be sent within 15 calendar days of receipt of a pre-service appeal and 20 business days of receipt of a post-service appeal.

Expedited stage II appeals

The stage II appeal will be processed as an expedited or urgent care appeal whenever the Member is confined in an inpatient facility, upon the request of the Member's Provider, and/or when we determine that a delay in decision-making based on non-expedited appeal time frames could seriously jeopardize the Member's life, health, or ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed while awaiting a non-expedited appeal decision. Expedited appeal review will be completed within 72 hours after our receipt of the appeal, and the final 48 hours (approximately) of that period are allotted for completion of any expedited stage II appeal that occurs after an expedited stage I appeal.

The stage II review will be conducted by an appeal panel, as described above. The Member, Member designee, and other Providers, as appropriate, will be notified of our decision on the expedited stage II appeal verbally or by fax within the final 48 hours of the 72-hour period following receipt of the original expedited appeal request. The letter with written confirmation of the expedited stage II decision will include an explanation of appeal rights, as appropriate. That decision letter will be sent to the Member, Member designee, and other Providers as appropriate, no later than the end of the 72-hour period after receipt of the original expedited appeal request.

External reviews

If the Member is dissatisfied with the outcome of the final internal appeal, the Member or Member designee may initiate an external review under the processes applicable to the Member's health plan. For most health plans, external review is conducted by an Independent Utilization Review Organization, Maximus, consistent with processes mandated by New Jersey State laws.

The Member or Member designee may initiate the external review within 4 months of receipt of the final internal appeal decision letter to Maximus. If Maximus accepts the appeal, it will issue a decision within 45 calendar days for a standard appeal and within 48 hours for an expedited request. The decision of the external review is binding on the Plan and Member. Additional information about the external review process, including instructions on how to file an external appeal, is documented in the final internal appeal decision letter. The Member/designee should electronically file the request by providing the required information to *https://njihcap.maximus.com*.

Members or designees who are unable to submit their requests electronically can download and print the appeal from the *Maximus website*. Members/designees may also contact Maximus by regular mail and/or by fax. The completed appeal form may be returned to Maximus by fax at 585-425-5296 or by mail to:

Maximus Federal-NJ IHCAP
3750 Monroe Avenue, 705
Pittsford, NY 14534

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

Also, note that the appeals procedures stated above may change due to changes in the applicable State and federal laws and regulations to satisfy standards of certain recognized accrediting organizations or to otherwise improve the Member appeals process. For additional information, contact Customer Service at the telephone number on the Member's ID card.

For AmeriHealth Administrators, please contact the number on the back of the Member's ID card for information on external reviews.

Administrative appeals

We maintain an administrative appeals process for any Member who is dissatisfied with our decision regarding claims or noncovered benefits. The administrative appeals process gives Members the opportunity to appeal adverse claims and noncovered benefits determinations. Each level of internal appeal is completed promptly, within the applicable time frames outlined on the following pages.

Member representatives

While decisions regarding claims and noncovered benefits may be appealed by the Member, such decisions may also be appealed by a Provider or other individual acting on behalf of the Member as the Member's designee if a valid consent or authorization form from the Member is provided to us. We also have staff members available to assist and/or represent Members in the appeals process.

Appeal classifications

Appeals of decisions regarding claims or non-covered benefits may also be referred to as pre-service appeals or post-service appeals. A pre-service appeal is for benefits that are covered only if Pre-approved/Pre-certified before medical care is obtained; all other appeals are post-service.

Appeal stages

As described on the following pages, the Member or Member designee has access to two internal stages of appeal — level I and level II. The level II appeals process is final unless the Member or Member designee chooses to contact appropriate external authorities as directed in the level II decision letter (see "Level II appeals" below).

Appeal decision-makers and time frames

Decision-makers for administrative appeals are individuals with no previous involvement in the decision at issue and are not subordinates of such individuals. Review of an administrative appeal is completed, and a written decision letter issued for each level of appeal within 15 calendar days of receipt of a first- or second-level request for a pre-service administrative

appeal and within 30 calendar days of receipt for a request for a post-service administrative appeal.

Information for the appeal review

At each appeal stage, all information gathered for the appeal review is considered by the decision- makers. This includes information obtained from our investigation, as well as any additional information submitted by the Member or Member designee. Upon request at any time during the appeal process, we will provide the Member or Member designee a copy of the correspondence, documents, medical records, and other information provided to the decision-makers for internal appeal review. We may delete from the copy provided to a Member or Member designee certain information that we consider confidential and/or proprietary.

Level I appeals

The Member or Member designee must request a level I appeal within 180 days of receipt of notice of a denied claim or a noncovered benefit. Instructions for filing a level I appeal are included in the notice letter. The Member or Member designee may call Customer Service at the telephone number on the Member's ID card or send a written appeal to:

AmeriHealth New Jersey Appeals Unit
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

The level I decision-maker will review all information obtained for the appeal from the Member and other sources. We will issue a written decision letter according to the time frames outlined previously.

Level II appeals

If the Member is not satisfied with the level I appeal decision, the Member or Member designee may request a level II appeal within 60 days of receipt of the level I decision letter. The level II appeal will be reviewed by a three-person committee of decision-makers. When arranging the committee meeting, we will notify the Member or Member designee of the meeting date, meeting procedures, and the Member's rights at the hearing. The Member and/or the Member designee also has the right to ask us to have a member of our staff who is not involved in the case represent the Member. We will issue a written decision letter according to the time frames outlined previously and the decision is final. Members or a Member designee who are dissatisfied with the outcome of the Level II appeal may file a complaint with the Department of Health and Senior Services and/or the Department of Banking and Insurance (DOBI) as directed in the level II decision letter.

Note: Members enrolled in self-funded plans, government-sponsored plans, and certain other plans are advised that their plans may have appeals procedures for administrative appeals decisions that are different than those previously stated. Members should check with the plan administrator or benefits manager for information regarding differences in policies, procedures, and benefits decisions for their plan.

Also, note that the appeal procedures previously stated may change due to changes in the applicable State and federal laws and regulations, to satisfy standards of certain recognized accrediting organizations or to otherwise improve the Member appeals process. For additional information, contact Customer Service at the number on the Member's ID card.

Provider claims appeal process

We maintain a Provider claims appeal process to resolve administrative disputes between carriers and Providers relating to payment of claims. If a Provider is dissatisfied with a claim decision related to billing/payment concerns, the Provider may appeal the claim decision under the AmeriHealth New Jersey Provider claims appeal process. A Provider who has received initial audit findings from the Corporate and Financial Investigation Department related to a claims payment determination may initiate the Provider claims appeal process described on the following pages. The AmeriHealth New Jersey Provider claims appeal process has two levels.

The New Jersey Public Law 2005 chapter 352, known as the Health Claims Authorization, Processing, and Payment Act (HCAPPA) allows submission of the form for AmeriHealth New Jersey Provider claim appeals.

First-level Provider appeals

In accordance with the provisions of HCAPPA, a health care Provider may initiate a first-level Provider appeal. The appeal must be initiated on or before the 90th calendar day following receipt of our claims determination using the *Health Care Provider Application to Appeal a Claims Determination* form, as specified by the New Jersey DOBI. Along with the DOBI form, the Provider should submit any additional relevant information in support of the appeal. A copy of this form is available on our website at *www.amerihealthnj.com/Resources/pdfs/7.5/AHNJ_provider_appeals_claim_form.pdf*.

The claim form and any supporting documentation can be sent to us using one of the following:

- **Fax:** 609-662-2610
- **Mail:**

  AmeriHealth New Jersey Provider Claim Appeals Unit
  259 Prospect Plains Road
  Building M
  Cranbury, NJ 08512

Do not submit a Health Care Provider Application to Appeal a Claims Determination IF: Our determination indicates that we concluded the health care services for which the claim was submitted were not medically necessary, were experimental or investigational, were cosmetic rather than medically necessary or dental rather than medical. *Instead*, you may submit a request for a Stage I UM Appeal Review, outlined in section 15.4 above, entitled *Stage I Appeals (internal)*.

Appeal arbitration

If the Provider disputes the appeal determination made by the carrier, the Provider may initiate an arbitration request through the New Jersey Program for Independent Claims Payment Arbitration (PICPA) by completing the PICPA form within 90 calendar days of receipt of the appeals decision. Claims are eligible for arbitration *only* if the original appeal was filed on the *Health Care Provider Application to Appeal a Claims Determination* form.

No dispute will be accepted for arbitration unless the payment amount in dispute is $1,000 or more; however, a health care Provider may aggregate his own disputed claim amounts for the purposes of meeting the requisite threshold requirements. No dispute pertaining to Medical Necessity that is eligible to be submitted to the Independent Health Care Appeals Program shall be subject to arbitration. For more information on the PICPA, visit *https://njpicpa.maximus.com*.

For more information regarding New Jersey Provider appeals and arbitration processes, refer to the State of New Jersey DOBI website at *www.state.nj.us/dobi/chap352/352implementnotice.html*.

The Provider claims appeal process has been modified in accordance with the Health Claims Authorization, Processing, and Payment Act.

Provider initial claims review process

Refer to the *Billing* section of this manual for information.

Other Provider claims review requests

If the Provider elects to dispute a claim outside of the Provider claims appeal process, such as a request for additional payment or question on reimbursement amount, please refer to the *Billing* section, Provider Claims Inquiry, for procedures on requesting a claims review.

ER services appeals

ER claims that do not meet the AmeriHealth criteria for an Emergency are automatically processed at the lowest ER payment rate in the fee schedule or as otherwise provided in the Professional Provider Agreement. To appeal an ER determination, complete an *Emergency Room Review Form* (available at *www.amerihealthnj.com/html/providers/provider_forms.html*), attach the Member's medical record, and submit to:

AmeriHealth New Jersey
Claims Medical Review Department
1901 Market Street, 30th Floor
Philadelphia, PA 19103

Provider complaints

A complaint is an expression of dissatisfaction regarding any aspect of the coverage, operations, or management of AmeriHealth New Jersey. Providers who are dissatisfied with any such aspect, including, but not limited to, our medical policy, network contracting, credentialing, capitation payments, or claims payment processes may call Customer Service at 1-888-YOUR-AH1. Most complaints can be resolved by Customer Service; however, some complaints may need to be forwarded to the appropriate area for further review and resolution. For example, complaints related to credentialing are forwarded to the Credentialing department for investigation and resolution.

Service-related complaints are forwarded to the responsible supervisor for review and action. Complaints regarding claims processing, payment, or adjustments are forwarded to the Adjustment Unit for resolution. The Adjustment Unit reviews the inquiry and adjusts the claim as appropriate. If during review the staff in the Adjustment Unit determines that the claim was adjudicated correctly, the Provider is notified of the outcome of the review and given instructions for filing an appeal (see *Provider claims appeal process*).