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PIP ALERT

ATTN: **Medical Providers/Billing Companies**
From: **Joseph A. Massood, Esq.**
Re: **New Appeals Process**
N.J.A.C. 11:3-4.7B

Effective April 17, 2017 the new appeals process takes effect. The insurance carriers are in the process of revising their Decision Point Review Plans. Overall, the new appeals process should be beneficial to billing companies and medical providers. The pre-service appeal and post service appeals process can get complicated. **Massood Law Group, LLC is available to educate the medical providers and billing companies on how to comply with the new appeals process**.

THE GOOD

1) One Level Appeal (Second Level Appeals have been eliminated).
2) Two types of Appeals;

a. Pre-service Appeal – For services that were denied but not yet performed, the medical provider must submit an appeal 30 days from the date of denial.

b. Post Service Appeal – For services that were denied after they were performed (all EOB denials, UCR, NCCI edits, Non-payment) the appeal must be submitted 45 days prior to instituting arbitration.

3) DOBI is in the process of creating uniform appeal forms.

4) Relaxed Standard if the medical provider misses the 30 day deadline. The Department seems to suggest if the medical provider fails to submit an appeal within 30 days from the date of the denial, the provider is not precluded from submitting another Decision Point Review Request and appeal that denial. DOBI's position appears to be the response to several Superior Court Decisions which overturned Arbitrators who dismissed the arbitration simply because the medical provider submitted the appeal out of time.

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.

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.

THE BAD

1) The appeal should contain all of the information the medical provider intends to reply upon at the time of the arbitration. Example: The medical provider files a post service UCR appeal. It appears that the medical provider is now required to list specifically the evidence which supports the medical provider's position (Ingenix, Fair Health, EOBs). Failure to do so could prevent the arbitration attorney from introducing this evidence at arbitration.

RESPONSE: The Department agrees that the internal appeal process is the primary forum where disputes about the medical necessity of treatment and billing disputes should be addressed. The purpose of this rulemaking is to provide a uniform, simple-to-use and rapid procedure for appealing insurer decisions. The lengthy, expensive arbitration process should be available to handle complex disputes. Consistent with the foregoing principles, the Department believes that all the relevant information about a dispute should be produced as part of the internal appeal process and only under extraordinary circumstances should additional information be presented as part of the arbitration. However, the Department believes that the arbitration process itself is the best place for such determinations to be made. Claimants and respondents should object to the submission of information additional to that contained in the record of the internal appeal and absent extraordinary circumstances, the DRP should not admit such information.

However, in the same page of the comments, the Department indicated that it was not feasible to have the medical provider and/or the insurance carrier submit all of the evidence in the appeal's process.

RESPONSE: The Department does not agree with the commenter's suggestions for changes to the rules. As noted above in response to another comment, the Department has determined that it is not feasible to have a rule that requires providers to submit all additional information in an appeal. Insurers should note in the response to such appeals that no new information in support of the treatment has been provided. The Department agrees that, as a general principle, neither claimants nor respondents should submit information at an arbitration that was available but not submitted at the internal appeal. Again, as noted above in response to another comment, the Department declines to put this as a requirement in the rule. The Department believes that the arbitration process itself is the best place for such determinations to be made. Claimants and respondents should object to the submission of information additional to that contained in the record of the internal appeal - especially when available to the submitter at precertification and/or appeal - and absent extraordinary circumstances, the DRP should not admit such information.

2) The medical provider may be required to file pre-service and post service appeals for the same service; pre-service appeal for services that were denied prior to being performed, and

post service appeal for services denied after being performed. There are just too many situations to explain in a PIP Alert. Below is just one example.

> COMMENT: One commenter recommends that the Department clarify N.J.A.C. 11:3-4.7B (b) to avoid the filing of a post-service appeal of a decision point/pre-certification denial that had been appealed by way of a pre-service appeal. For example, a provider submits a request for a proposed treatment that is denied by the insurer. The provider submits a pre-service appeal that is also denied. The service is performed and the provider submits the bill to the insurer for payment. The insurer sends an EOB that denies reimbursement based on the prior medical necessity denial. The present language of the regulation may suggest to the provider that a post-service appeal may be filed challenging what the insurer should reimburse. The commenter stated that this would create administrative difficulties for insurers to reply to such appeals. The commenter suggested that the following change would eliminate any confusion (addition in bold):
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> > (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/or durable medical equipment on the grounds of medical necessity is different issue than an appeal of what the insurer should reimburse the provider for a service that the insurer has approved as medically necessary.
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> RESPONSE: The Department agrees with the example provided by the commenter, but does not agree that additional language needs to be added to the rule. Insurers are permitted to file language in accordance with N.J.A.C. 11:3-4.9(b) that requires providers who are assigned benefits by the insured to complete an internal appeal prior to requesting alternate dispute resolution pursuant to N.J.A.C. 11:3-5. In that policy language, an insurer may also require that appeals of denials of Decision Point Review or Precertification requests be made as pre-service appeals. If such appeal was denied, the provider could request alternate dispute resolution on that issue but would not be permitted to make a post-service appeal of medical necessity since, in accordance with the one-level appeal limit, the issue of medical necessity had already been appealed.

Billing Companies and medical providers can make arrangements with *Massood Law Group, LLC* to file their post service appeals on their behalf or assist them in doing so. As soon as DOBI publishes their appeal forms I will provide you with further information.
