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November 9, 2015

PIP ALERT

To access the proposed regulation please go to **www.mbhurt.com** and click on PIP Alert

From: **Joseph A. Massood, Esq.**

Re: **DOBI's Proposed Appeal's Process**

Attached please find DOBI's Proposed Appeal's Process. The Proposed Regulations appear to contradict themselves concerning whether treatment appeals must be filed within 5 business days or 30 calendar days from an adverse decision which I will discuss later. **Please note that all time frames are calendar days except treatment appeals which are 5 business days.**

The good news:

1) Universal Appeals Process, which all Insurance Carriers and Medical Providers must follow.

2) Two types of appeals: treatment appeal (medical necessity) and administrative appeals.

3) Only one level appeal; no second or third level appeals required anymore.

4) Administrative appeals (i.e., all appeals other than medical necessity) must be filed within 180 calendar days of an adverse decision.

5) Standard Appeal Form Application- This will allow you to prepare the appeal in advance of the denial. You must include the correct insurance claim number, date of loss, patient's name, and respond with specificity to the adverse decision.

The bad news:

1) Treatment appeals (medical necessity appeals) must be filed within 5 business days of an adverse decision (Page 11).

2) If the medical provider does not submit the appeal within 5 business days from the adverse decision, the medical provider may re-submit the pre-certification request for the treatment prior to the services being performed.

3) The regulations are unclear as to what occurs if the medical provider **performs** the services but fails to appeal the adverse medical decision within 5 business days. The insurance carrier will certainly argue that the medical provider is forever barred. Medical providers need to write to the Department of Banking and Insurance for clarification. Pursuant to N.J.A.C. 11:3-4.7 B (e) (Page 14) DOBI states that **pre-service appeals** shall not be submitted no later than 30 calendar days after an adverse decision. Under this scenario, a medical provider would have 30 calendar days (not 5 business days) to appeal an adverse medical decision provided the services were not performed. The medical provider should write to DOBI insisting that a medical provider should have at least 30 calendar days to file an appeal to an adverse treatment request (medical necessity) **even if the procedure has been performed.**

4) Incomplete Appeals- If the medical provider fails to provide the following information:

   A. A specific response to the adverse pre-certification denial.
   B. Correct insurance claim number, date of loss, patient's name.

   The insurance carrier does not have to accept the appeal because it is an incomplete appeal and it shall not constitute a valid appeal. **The problem**: what happens if the medical provider receives notice from the insurance carrier that the appeal is deficient but the time frames have expired for the medical provider to submit a complete appeal? There should be a specific provision that states if the medical provider receives notice from the insurance carrier that the appeal is incomplete, the medical provider shall have 30 calendar days to submit a completed appeal. The medical provider should write to DOBI on this issue.

47 NJR 11(2)
November 2, 2015
Filed October 8, 2015

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF PROPERTY AND CASUALTY

Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests

Requirements for Insurer Internal Appeals Procedures

Proposed Amendments: N.J.A.C. 11:3-4.2 and 4.9

Proposed Repeal and New Rule: N.J.A.C. 11:3-4.7B

Authorized By: Richard J. Badolato, Acting Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17:29A-14.c(4), 17:33B-42, 39:6A-1.2, 39:6A-3.1, 39:6A-4, 39:6A-4.3, 39:6A-5.1, 39:6A-5.2, and 39:6A-19.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2015-140.

Submit comments by January 1, 2016, to:

Denise Illes, Chief

Legislation and Regulation

New Jersey Department of Banking and Insurance

20 West State Street

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Trenton, NJ 08625-0325

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The agency proposal follows:

Summary

On August 1, 2011, the Department proposed a new rule at N.J.A.C. 11:3-4.7B to establish standards for a uniform internal appeal process for disputes under Personal Injury Protection (PIP) coverage of the automobile insurance policy (see 43 N.J.R. 1640(a)). Pursuant to N.J.A.C. 11:3-4.7(c)6, insurers have always been required to have an internal appeal process as part of their Decision Point Review plans. However, the details of these plans varied considerably among insurers, which made it complicated and burdensome for providers to make these appeals. The new appeal process proposed at that time was based on that used by the Department for utilization management appeals in health plans.

The Department received many comments on the proposal of N.J.A.C. 11:3-4.7B. The Department agreed with many of the comments and on November 5, 2012 (see 44 N.J.R. 2652(c)), the Department adopted N.J.A.C. 11:3-4.7B but with a delayed operative date of November 5, 2013. The Department subsequently delayed the operative date until November 5, 2014 (see 45 N.J.R. 2392(a)) and then again until November 5, 2015 (see 46 N.J.R. 2159(a)). The delayed operative date permitted the Department to consult with interested parties and draft amendments to the rule in response to the comments. The Department is now proposing to repeal and replace N.J.A.C. 11:3-4.7B along with amendments to N.J.A.C. 11:3-4.2, Definitions, and 11:3-4.9, Assignment of benefits; public information. The Department recognized that the internal appeal process needed to be repealed and replaced in its entirety. After extensive consultation with interested parties, the Department has determined to simplify the requirements for internal appeals.

The internal appeal procedure that was adopted effective November 12, 2012, and the proposed new rule are similar in several respects. They both require that insurers have a one-level appeal system and they both divide appeals into two basic categories: pre-service and post-service appeals. Both procedures include time frames for the filing of and response to appeals and require that the Department establish a uniform appeal form. The rule proposed for repeal also contained detailed requirements for proving that the appeals were submitted, provisions for designating appeals as incomplete, a requirement that insurers mandate that a provider file an internal appeal prior to initiating arbitration, and sanctions for providers and insurers that did not follow the rules. As noted above after receiving comments as part of the Executive Order No. 2 process, the Department determined that these provisions were not necessary.

N.J.A.C. 11:3-4.2 is proposed to delete the example in paragraph 3 under the definition of the term "days." The example refers to provisions that are no longer in the rules.

Proposed new N.J.A.C. 11:3-4.7B(a) states that the internal appeal procedure in the insurer's Decision Point Review plan shall meet the requirements that follow in the rule.

Proposed new N.J.A.C. 11:3-4.7B(b) states that internal appeal procedures shall be one level for each issue being appealed. The medical necessity for a service and what should be reimbursed for a service are different issues. The Department believes that a one-level appeal process provides sufficient opportunity for the insurer to review the issue being appealed. It also promotes the goal of uniformity among insurers.

Proposed new N.J.A.C. 11:3-4.7B(c) states that all appeals shall be initiated on forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). This provision is recodified from existing N.J.A.C. 11:3-4.7B(d) and amended to require that the appeal form be posted on the Department's website.

Proposed new N.J.A.C. 11:3-4.7B(d) states that appeal forms and documentation shall be submitted by the provider in accordance with the insurer's Decision Point Review (DPR) plan. Insurers may permit electronic filing of appeals in accordance with N.J.A.C. 11:1-47, Electronic Transactions, and by providing for the process in its DPR plan.

Proposed new N.J.A.C. 11:3-4.7B(e) states that there shall be two types of internal appeals.

Proposed new N.J.A.C. 11:3-4.7B(e)1 defines pre-service appeals as 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."

Proposed new N.J.A.C. 11:3-4.7B(e)2 defines post-service appeals as those made subsequent to the performance or issuance of the services.

Proposed new N.J.A.C. 11:3-4.7B(f) states that pre-service appeals shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

Proposed new N.J.A.C. 11:3-4.7B(g) states that post-service appeals 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.

Proposed new N.J.A.C. 11:3-4.7B(h) states that 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.

Proposed new N.J.A.C. 11:3-4.7B(i) states that 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.

N.J.A.C. 11:3-4.7B(f) is relocated as N.J.A.C. 11:3-4.7B(j) with no change in text. The subsection provides that nothing in the 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).

N.J.A.C. 11:3-4.9(b) is proposed to be amended to permit, rather than require, that insurers file policy language requiring that providers who are assigned benefits or have a power of attorney from the insured make an internal appeal in accordance with N.J.A.C. 11:3-4.7B prior to making a request for dispute resolution in accordance with N.J.A.C. 11:3-5.

A 60-day comment period is provided for in this notice of proposal and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The Department's proposed new rule and amendments will promote the cost efficient provision of quality medical care to persons injured in automobile accidents. The Department believes that the new rule and amendments will have a positive social impact on insureds and insurers.

The proposed new rule at N.J.A.C. 11:3-4.7B will benefit insureds and providers by requiring that insurers provide a simple and uniform internal appeal process. The internal appeal process will allow providers to get a rapid review of adverse decisions by insurers on treatment requests and on issues about payment for services. Although insurers are currently required to have an internal appeal process, the requirements vary among insurers. The uniform process created by the proposed new rule and amendments will make it easier for providers to make such appeals.

Economic Impact

The proposed new rule and amendments will affect private passenger automobile insurers, insureds, and medical providers who treat PIP patients. The rule and amendments are intended to establish limits on the amount of medical expenses paid by insurers on behalf of New Jersey residents who are injured in automobile or bus accidents, thereby lowering the cost of automobile personal injury protection coverage and motor bus medical expense coverage in New Jersey.

The Department believes that the proposed new rule and amendments will have a favorable economic impact on insurers and providers by eliminating many costly disputes and arbitration proceedings.

The new rule and amendments should also reduce inefficiency in billing and payment fraud and enhance competition, all of which should exert downward pressure on private passenger auto insurance rates.

The Department does not believe that the costs of the new rule and amendments for insurers and providers will be substantial since the new rule and amendments standardize the current internal appeal process; therefore, there may be minimum cost associated with forms being amended.

Federal Standards Statement

A Federal standards analysis is not required because the proposed new rule and amendments are not subject to any Federal requirements or standards.

Jobs Impact

The Department does not anticipate that any jobs will be generated or lost as a result of the proposed new rule and amendments. The Department invites commenters to submit any data

or studies about the jobs impact of these proposed new rule and amendments together with their comments on other aspects of the proposal.

Agriculture Industry Impact

The proposed new rule and amendments will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

These proposed new rule and amendments will impose reporting, recordkeeping, and compliance requirements on "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent the proposed new rule and amendments apply to small businesses, they will apply to New Jersey domiciled PPA (private passenger automobile) insurers and New Jersey resident providers. The proposed requirements are discussed in the Summary above; the economic impacts and costs of compliance for these entities are set forth in the Economic Impact above.

The proposed new rule and amendments provide no differentiation in compliance requirements based on business size. As noted above, the Department believes that any costs that may be imposed will be outweighed by the benefits to be achieved, which include a reduction in the upward pressure on PPA insurance rates generated by current PIP medical expense costs. The goal of the proposed new rule and amendments is to ensure the uniform regulation of internal appeals. The Department does not anticipate that professional services will be necessary for continued compliance with the new rule and amendments. To the extent the use of professional services are necessary, these costs will vary with individual professional services and the need of the insurer.

Housing Affordability Impact Analysis

The proposed new rule and amendments will not have an impact on housing affordability in this State in that the proposed new rule and amendments relate to the provision of PPA insurance in this State.

Smart Growth Development Impact Analysis

The proposed new rule and amendments will not have an impact on smart growth in this State and there is an extreme unlikelihood that the rules would evoke a change in housing production in Planning Areas 1 or 2 or within designated centers under the State Development and Redevelopment Plan in New Jersey in that the proposed new rule and amendments relate to the provision of PPA insurance in this State.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indcated in brackets [thus]):

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

11:3-4.2 Definitions

The following words, phrases**,** and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

…

"Days" means calendar days unless specifically designated as business days.

1. (No change.)

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last

day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday**,** or legal holiday.

[3. Example: Decisions on treatment appeals shall be communicated to the provider no later than 10 days from the date the insurer acknowledges receipt to the provider. The insurer acknowledges receipt by facsimile transmission dated 3:00 P.M. on Wednesday, June 8. Day one of the 10-day period is Thursday, June 9. Since the 10th day would be Saturday, June 18, the insurer's decision is due no later than Monday, June 20.]

…

11:3-4.7B **Requirements for insurer** [Interal] **internal** appeals procedure**s**

[(a) The internal appeals process shall permit a provider who has been assigned benefits pursuant to N.J.A.C. 11:3-4.9 or has a power of attorney from the insured to submit additional information and have a rapid review of an adverse decision by the insurer.

(b) An adverse decision is any determination by the insurer with which the provider does not agree and includes, but is not limited to:

1. Determinations of medical necessity for treatment or testing requested by the provider via a properly completed Decision Point Review/Precertification Request;

2. Disputes about whether the insured's injuries were caused by a motor vehicle accident;

3. Disputes between the insurer and the provider concerning the time of notificiation, receipt, and submission of Decision Point Review/Precertificaion requests or other notifications required by N.J.A.C. 11:3-4;

4. Disputes about the imposition of the deductibles and copayments in N.J.A.C. 11:3-4.4;

5. A provider's claim that a payment from the insurer is overdue pursuant to N.J.S.A. 39:6A-5g;

6. Disputes involving a provider's usual, customary and reasonable fee; or

7. Disputes about coding, including, but not limited to: which HCPCS, CPT or CDT code properly represents the service performed, sometimes known as downcoding; the use of unlisted codes; and the application of the NCCI edits.

(c) There are two types of internal appeals:

1. Treatment appeals about the medical necessity of future treatment or testing that was requested by the provider on a properly completed Decision Point Review/Precertification Request; and

2. Administrative appeals for all other types of adverse decisions.

(d) All appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). The appeal form and any supporting documentation shall be submitted by the provider to the address or fax number designated for appeals in the insurer's DPR plan.

1. The insurer's DPR plan shall include a regular mailing address and a fax number for filing appeals. The insurer may also establish a procedure in its DPR plan for the submission and acknowledgment of appeals by electronic means.

2. The appeal form from the provider must reference the correct insurance claim number, date of loss and patient name, clearly identify the adverse decision that is the basis for

the appeal and must have been sent to the address or fax number designated for appeals in the insurer's DPR plan.

3. For appeals, acknowledgments and decisions sent by regular mail, it shall be the responsibility of the sender to provide proof that the item was mailed.

4. A confirmation generated by a fax machine or computer that shows the time, date, and fax number of the sending and receiving machine shall be evidence that the appeal, acknowledgment or decision was faxed and received. The insurer must accept fax confirmations.

5. For appeals, acknowledgments and decisions sent by regular mail, the postmark date shall be considered as the date the appeal, decision or acknowledgment was mailed.

(e) A treatment appeal shall be submitted no later than five business days after the provider has received notice of the adverse decision that is the basis for the appeal.

1. Treatment appeals that are not submitted in accordance with the time frame in (e) above may not be submitted as administrative appeals. If a provider misses the deadline to submit a treatment appeal, he or she may submit another decision point review request for the treatment or testing in accordance with the insurer's DPR plan.

(f) Nothing in this section shall be construed so as to require reimbursement of tests or treatments 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).

(g) An administrative appeal shall be submitted within 180 days of the adverse decision that is the basis for the appeal.

(h) The insurer shall acknowledge receipt of the appeal by regular mail, fax or electronic means on a form established by the Department by Order pursuant to N.J.A.C. 11:3-4.7(d).

1. The receipt of treatment appeals shall be acknowledged within three business days.

2. The receipt of administrative appeals shall be acknowledged within five business days.

3. Appeals received without the information required by (d)2 above shall be acknowledged in the time frames set forth above as "Incomplete" and with the missing or incorrect information noted. Appeals received after the deadlines in (e) and (g) above shall be acknowledged as "Late Appeals." An incomplete filing or late appeal does not constitute an appeal pursuant to this subchapter.

(i) The insurer shall conduct a review of the appeal and notify the provider of its decision by fax, mail or electronic means. The insurer may contact the provider by telephone but must follow up with a written decision that is transmitted as described (h) above.

1. Decisions on treatment appeals shall be received by the provider who submitted the appeal no later than 10 days from the date the provider receives the acknowledgment of the appeal.

2. Decisions on administrative appeals shall be received by the provider who submitted the appeal no later than 30 days from the date the provider receives the acknowledgment of the appeal.

3. An insurer may determine that a physical examination pursuant to N.J.A.C. 11:3-4.7(e) is necessary to respond to the appeal. In that case the time periods in (i)1 and 2 above shall start after the examination has been conducted and the report received.

(j) Pursuant to N.J.A.C. 11:3-5.6(a)2, a provider acting on assignment or the holder of a power of attorney from the insured must have filed an internal appeal prior to filing for alternate

dispute resolution pursuant to N.J.A.C. 11:3-5. The demand for arbitration must be accompanied by the internal appeal decision or proof that the appeal was filed. The rules of the dispute resolution administrator shall set forth how such proof shall be submitted.

1. The rules of the dispute resolution adminstrator shall include penalties for providers and their attorneys who make arbitration demands without having exhausted the internal appeals process.

(k) An insurer that fails to respond to an internal appeal filed in accordance with (a) through (i) above shall lose the right to raise defenses in an arbitration on the issue that was the subject of the appeal. However, the insurer can raise other valid and relevant defenses in the arbitration. Example: A provider makes a decision point review request for treatment, which is denied by the insurer as not being medically necessary. The provider appeals the decision in accordance with the procedures in this subchapter. The insurer fails to respond to the appeal and the provider makes a demand for arbitration. By failing to respond to the appeal, the insurer loses the right to argue that the treatment requested in the Decision Point Review was not medically necessary. However, the insurer is not precluded from raising other defenses at the arbitration proceeding.]

(a) The internal appeal procedure in an insurer's Decision Point Review Plan (DPR Plan) shall meet the requirements in 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/or durable medical equipment on the grounds

of medical necessity is 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. 11:1-47, 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:

1. 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 documention.

(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).

11:3-4.9 Assignment of benefits; public information

(a) (No change.)

(b) Insurers [shall] **may** file policy language requiring that providers who are assigned benefits by the insured or have a power of attorney from the insured make an internal appeal pursuant to N.J.A.C. 11:3-4.7B prior to making a request for dispute resolution in accordance with N.J.A.C. 11:3-5.

(c) (No change.)