A Message to

Business Office Managers

North NJ Office: 485 Route 1 South, Building C, Iselin, NJ 08830

To: Managers and Administrators of AmeriHealth Participating Hospitals and Ancillary Facilities in New Jersey

From: Kathleen Sullivan, R.N.
Director, Hospital & Ancillary Contracting/ NJ Non Contiguous region

Date: July 9, 2004

RE: CLAIM PAYMENT APPEAL PROCESS

This bulletin serves as a reminder to you of the process that AmeriHealth has in place for hospitals, physicians and other providers to appeal a claim payment for reasons other than medical utilization management determinations. This information was distributed to all participating hospitals and providers by bulletin release and contract amendment in 2001. This process is also contained in the 2002 AmeriHealth Hospital Manual, Section IX, page 69-70.

To informally resolve a complaint concerning claim payment, other than for UM denials, please call Provider Service as a first step. Many issues can be resolved at this level. AmeriHealth Provider Service telephone numbers are:
HMO Coverages: 800-821-9412
PPO Coverages 800-595-3627

Provider Claims Appeal Process

1. AmeriHealth maintains a provider claims appeals process to resolve disputes between carriers and participating providers relating to payment of claims, but not including disputes made pursuant to N.J.A.C. 8:38-8.5 through 8.7 and 8:38A-3.6 and 3.7 regarding utilization management determinations. If a provider is not satisfied with the outcome of an informal complaint to resolve a claim decision or chooses not to informally resolve the claim decision, the provider may appeal the claim decision under the AmeriHealth Provider Claims Appeal Process. The AmeriHealth Provider Claims Appeal Process has two stages. The first stage is an internal appeal and the second stage is an external review.

2. **Internal Appeal Process:**

a. To initiate an internal appeal regarding a claim decision, the provider shall submit a written request for an internal appeal within 60 calendar days of receipt of a claim decision that results from a review under the provider complaint process following the submission of a complaint. The request should be sent to:

Claims Payment Appeal Unit
P.O. Box 7218
Philadelphia, PA 19101

This PO BOX is ONLY for Claim Payment Appeals.
Do not submit medical appeals or other correspondence to this address.

b. The request should be accompanied by any documentation the provider believes supports his appeal, including but not limited to, medical records, documentation of extenuating circumstances, literature from a recognized medical society, etc.

c. Once the request for an appeal is received, the Appeals Unit will assign the appeal to an AmeriHealth Appeals Unit Specialist for review.

d. The review shall be conducted by Specialists who are not responsible for claims decisions on a day-to-day basis.

e. The Claims Appeal Committee will review the appealed claim decision and notify the provider of its claim decision in writing within ten (10) business days following receipt of the appeal.

f. The Claims Appeal Committee's written decision shall include: a statement of the participating provider's appeal; an explanation of the basis for such a decision; a description of the evidence or documentation which supports the decision; and, if the decision is adverse, a description of the method to obtain an external review of the decision.

3. **External Appeal Process/Alternate Dispute Resolution ("ADR"):**

a. If the Claims Appeal Committee's decision is adverse, the provider may initiate an external appeal through a non-binding independent ADR process. The provider must submit a written request within thirty (30) calendar days of receipt of the claim decision of the internal appeals committee to the AmeriHealth designated ADR Administrator.

b. The ADR Administrator shall notify AmeriHealth of the request by the Provider for an external appeal.

c. The ADR Administrator shall notify the Appeals unit if they require additional information necessary to review the claim.

d. The ADR Administrator shall notify AmeriHealth and the provider in writing of its recommended decision no later than thirty (30) business days following receipt of all documentation necessary to complete its review of the claim.

e. If the decision of the ADR Administrator is non-binding, AmeriHealth and provider may agree otherwise within ten (10) business days following receipt of the recommended decision by the ADR Administrator.

f. Costs associated with the ADR process will be borne equally by the provider and AmeriHealth.