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## **Medical Necessity appeals**

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We assume an active role in working with Physicians, hospitals, and other health care providers in authorizing and monitoring the utilization of covered health services. All cases with questionable medical appropriateness, delays in service, or reduction in service are referred to and reviewed by a Medical Director.

We shall approve coverage for the case if the request is for a Covered Service, sufficient information has been provided to us, and the services are medically appropriate. If a Medical Director determines that the clinical information provided by the attending Physician is insufficient to support Medical Necessity/appropriateness, coverage for the case may be denied and an appeal would be offered.

All coverage determinations are communicated verbally, and a letter is sent to the Member, attending Physician, hospital, and Primary Care Physician (PCP), when appropriate. Clinical review criteria, medical policy, or other internal guidelines are available and furnished upon request.

All denial notifications, whether verbal or written, include the reason for the denial and information on how to initiate an appeal.

## **Member or provider on behalf of Member appeals process**

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There are two broad types of appeals — 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. 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. (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 Physician) 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 precertified or Preapproved 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 Physician 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)**

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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 Physician designee will conduct a review and a decision will be issued. An AmeriHealth New Jersey Medical Director or Physician 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 nonexpedited.

**Nonexpedited stage I appeals**

Nonexpedited (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 five business 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 Physician, and/or when we determine that a delay in decision-making based on nonexpedited 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 nonexpedited 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)**

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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 60 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 Physicians 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 practitioner (a matched specialist with no prior involvement in the case) to be available to participate in the panel's review of the case.

### **Nonexpedited stage II appeals**

For nonexpedited (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, within 15 calendar days of receipt of the appeal. A decision letter providing written notice of the stage II decision and an explanation of appeal rights, as appropriate, will also be sent within 15 calendar days of receipt of the stage II appeal request.

### **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 Physician, and/or when we determine that a delay in decision-making based on nonexpedited 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 nonexpedited 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

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If the Member is dissatisfied with the outcome of the stage II 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 (IURO) consistent with processes mandated by New Jersey State laws. However, other authorities may be designated to conduct external review for Members of self-funded plans or health plans for government employees.

For plans subject to New Jersey State-mandated requirements, the Member or Member designee may initiate the external review within 120 days of receipt of the stage II determination to an IURO. If the IURO accepts the appeal, it will issue a decision within 30 business days of receiving all necessary documentation to complete the review. The IURO may extend its review period for a reasonable period of time due to circumstances beyond its control. In such an event, the IURO must provide written notice to the Member and/or Member designee prior to the end of the original 30 business-day review period setting forth the reasons for the delay. A decision reached by an IURO that is adverse to the Plan is binding to the Plan. A Member or Member designee may appeal directly to the IURO if the Plan waives its right to an internal review or fails to meet the time frames for completing stage I or stage II of the internal appeals process.

To request an external review, follow the instructions in the decision letter for the AmeriHealth New Jersey stage II appeal. A Member who has questions or is enrolled in a self-funded plan or plan for government employees should check with the plan administrator or benefits manager regarding external review procedures that may be available.

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.

Members or Member designees with written Member consent/authorization have the right to appeal coverage determinations within 180 days by calling **1-877-585-5731**, or by writing to:

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

## Medicare Advantage HMO appeals and grievance processes

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### Medicare Advantage HMO appeals (AmeriHealth 65<sup>®</sup> NJ HMO)

An AmeriHealth 65 NJ HMO Member, the Member's appointed representative, or the provider on behalf of the Member may request an appeal of any coverage decision about payment for or the failure to arrange or to continue to arrange for, what the Member believes are Covered Services under AmeriHealth 65 NJ HMO including noncovered Medicare benefits. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause.

A decision about medical care that has not already been rendered is called a pre-service appeal. Pre-service appeals are resolved as expeditiously as required by the Member's health condition, but in no more than 30 calendar days after the appeal is received; an extension of up to 14 calendar days is permitted for a pre-service appeal if the Member requests it, or if the AmeriHealth New Jersey Medical Director finds that the delay is in the best interest of the Member, without harm to the Member's health.



The Member or his or her appointed representative should mail the written appeal to:

AmeriHealth 65 NJ HMO Member Appeals Department  
P.O. Box 13652  
Philadelphia, PA 19101-3652

If the Member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard 30-day pre-service appeal process, an expedited appeal of a pre-service request may occur at the request of the Member, the Member's appointed representative, or at the request of the Member's Physician. Expedited appeals are resolved as expeditiously as required by the Member's health condition, but in no more than 72 hours upon receipt of the appeal request. All Member requests for an expedited appeal with Physician support or requests for an expedited appeal from a Physician are automatically handled as expedited appeals.

The Member or his or her appointed representative should contact us by telephone or fax:

AmeriHealth 65 NJ HMO: [1-877-585-5731](tel:1-877-585-5731)  
TTY/TDD: [1-888-857-4816](tel:1-888-857-4816)  
Fax: [609-662-2480](tel:609-662-2480)

A decision about payment for care is called a post-service appeal and must be resolved no later than 60 calendar days after the appeal is received.

If the original denial is upheld after review by us, the case is forwarded for review and determination by an independent review entity (IRE), who is contracted by the Centers for Medicare & Medicaid Services (CMS).

### **Timely submission of Medicare Advantage HMO Members' medical records**

As part of the federally mandated Medicare Advantage Appeals and Grievances process, AmeriHealth New Jersey is required to obtain a Member's medical record in order to make a determination of coverage. Should we uphold our determination, we are required to forward the Member's appeal file, which includes medical records, to an IRE. An IRE is contracted with CMS to perform second-level independent reviews of Medicare Advantage Members' appeals. Medical records must be submitted to us in a timely manner. By doing so, we can submit them to an IRE and ensure compliance with mandated appeal deadlines.

CMS also requires that both AmeriHealth New Jersey and an IRE make their determinations within 72 hours for an expedited appeal and within 30 days for a standard appeal. If a Member requests an expedited review, we will immediately send a request to the provider for medical records. We must receive the records within 24 hours for an expedited appeal and within ten days for a standard appeal. If an appeal is sent to an IRE, the IRE may request additional records, which are required to be sent under the same time frames.

Upon our request, and in accordance with your agreement, you must provide us with copies of a Medicare Advantage HMO Member's medical records as requested.

Other reasons we may require the timely submission of medical records include:

- facilitating the delivery of appropriate health care services to Medicare Advantage HMO Members;
- assisting with utilization review decisions, including those related to disease management programs, quality management, grievances (as previously discussed), claims adjudication, and other administrative programs;



- complying with applicable State and federal laws and accrediting body requirements (e.g., National Committee for Quality Assurance);
- facilitating the sharing of such records among health care providers directly involved with the Member's care.

### Skilled nursing facility and home health discharges

There is a special type of appeal that applies only to discharges when coverage will end with a Skilled Nursing Facility (SNF), home health, or comprehensive outpatient rehabilitation facility services. Members receive notice two days before coverage ends. If the Member thinks his or her coverage is ending too soon, the Member may appeal no later than noon the day before coverage ends. The appeal should be sent to:

Healthcare Quality Strategies, Inc.  
557 Cranbury Road, Suite 21  
East Brunswick, NJ 08816  
Phone: [1-800-624-4557](tel:1-800-624-4557) or [732-238-5570](tel:732-238-5570)

If the Member makes this type of appeal, his or her stay may be covered during the time period Healthcare Quality Strategies, Inc. (HQSI) uses to make its determination. The Member must act very quickly to make this type of appeal, and it will be decided quickly.

### Hospital discharges

Another special type of appeal applies only to hospital discharges. If the Member thinks his or her coverage of a hospital stay is ending too soon, the Member may appeal directly and immediately to HQSI. If the Member makes this type of appeal, his or her stay may be covered during the time period HQSI uses to make its determination.

### Medicare Advantage HMO grievance

A Medicare Advantage HMO grievance is any complaint or dispute raised by a Medicare Advantage HMO Member or the Member's appointed representative, other than a dispute involving a coverage determination. Medicare Advantage HMO grievances may include disputes regarding such issues as office waiting times, Physician behavior, adequacy of facilities, or involuntary disenrollment situations. A decision will be issued no later than 30 calendar days after the grievance is received. An extension of up to 14 calendar days is permitted if the Member requests or if AmeriHealth New Jersey requires more information and the delay is in the best interest of the Member. In certain cases, the Member has the right to ask for an expedited grievance, meaning we must issue a decision within 24 hours. We may extend the time frame by up to 14 calendar days if the Member requests the extension or if we justify a need for additional information and the delay is in the best interest of the Member.

## Medicare Part D appeals and grievances

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### Medicare Part D appeals

An AmeriHealth 65 NJ HMO Member, the Member's appointed representative, or the Member's prescribing Physician on behalf of the Member may appeal our decision not to cover a drug, vaccine, or other Part D benefit. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause. There are two types of appeals:

- **Standard appeals** are resolved as expeditiously as the Member's health condition requires, but no later than seven calendar days after we receive the appeal request. The Member or his or her appointed representative should mail the written appeal to:
  - AmeriHealth 65 NJ HMO Member Appeals Department
  - P.O. Box 13652
  - Philadelphia, PA 19101-3652
  
- **Expedited appeals** are resolved within 72 hours upon receipt of the appeal, or sooner if the Member's health condition requires. The Member or his or her appointed representative should contact us by telephone or fax at:
 

AmeriHealth 65 NJ HMO:	1-800-645-3965
TTY/TDD:	1-888-857-4816
Fax:	215-988-2001

If the original denial is upheld after the review by AmeriHealth 65 NJ HMO, the Member or the Member's appointed representative has the right to ask for a review and determination by an IRE, which is contracted by CMS.

### Medicare Part D grievances

A grievance is any complaint other than one that involves a coverage determination. The Member may file a grievance if he or she has any type of problem with AmeriHealth 65 NJ HMO or one of our network pharmacies that does not relate to coverage for a prescription drug. Grievances must be decided no later than 30 calendar days after receiving the complaint. In certain cases, the Member has the right to ask for an expedited grievance, meaning we must issue a decision within 24 hours. We may extend the time frame by up to 14 calendar days if the Member requests the extension or if we justify a need for additional information and the delay is in the Member's best interest.

*Note:* These procedures may change due to changes in applicable State and federal laws and regulations.

## Administrative appeals

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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 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 noncovered 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 precertified or Preapproved 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. The decision is final unless the Member or Member designee contacts 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**

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We maintain a provider claims appeal process to resolve disputes between carriers and Participating Providers relating to payment of claims. If a provider is dissatisfied with a claim decision following the submission of a complaint regarding the claim decision, 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 Senate Bill 2824, known as the Health Claims Authorization, Processing, and Payment Act (HCAPPA) requires submission of the form for all 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.amerihealth.com/pdfs/providers/interactive\\_tools/forms/appeals\\_claim\\_form.pdf](http://www.amerihealth.com/pdfs/providers/interactive_tools/forms/appeals_claim_form.pdf).

Send the claim form and any supporting documentation to:

AmeriHealth New Jersey  
 Provider Claim Appeals Unit  
 P.O. Box 7218  
 Philadelphia, PA 19101

### **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://njpica.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](http://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.

## ER services appeals

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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 Agreement. To appeal an ER determination, complete an *Emergency Room Review Form* (available at [www.amerhealth.com/providerforms](http://www.amerhealth.com/providerforms)), attach the Member's medical record, and submit to:

Claims Medical Review – Emergency Room Review  
AmeriHealth New Jersey  
Attn: Appeals  
259 Prospect Plain Road, Building M  
Cranbury, NJ 08512

## Provider complaints

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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*).