A NEW JERSEY GUIDE TO INSURANCE APPEALS:

Understanding How To Contest Adverse Benefit Determinations in the State

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New Jersey Appleseed Public Interest Law Center is 501(c)(3) that is dedicated to assisting members of the public in confronting pressing and complex problems that threaten their communities and their lives. In the area of health care, we have been working with the New Jersey for Healthcare Coalition to ensure the proper, effective, and fair implementation of the Affordable Care Act in New Jersey. This manual grew out of Appleseed's work as a subcontractor on the New Jersey Sentinel Project, a two-year project of Seton Hall Law School's Center for Health & Pharmaceutical Law & Policy funded by the Robert Wood Johnson Foundation to assess implementation of the Affordable Care Act's essential health benefits requirement by state-regulated individual and small group insurance plans.

TABLE OF CONTENTS

HOW TO USE THIS GUIDE 1
CHAPTER 1: PREPARING AN APPEAL 2
What Is an Insurance Denial? 2
What Is Not an Insurance Denial? 3
Timelines (Applicable to State regulated plans) 4
Getting Organized 5
Understanding Your Insurance Plan 6
Requesting Your Claim File 8
Talk to Your Doctor 9
CHAPTER 2: WRITING YOUR APPEAL AND WHAT HAPPENS NEXT 10
Suggestions on How to Write Your Appeal 10
What Happens Next? Internal Appeals 12
Requesting an External Review 14
CHAPTER 3: SPECIAL CONCERNS BASED ON TYPE OF PLAN 16
Employment-Based Self-Funded Plans 16
Medicaid/NJ FamilyCare 17
Medicare 21
Government Employees 23
New Jersey State Employees 23
Federal Employees 25
Veterans Health Care and Military Programs 26
CONCLUSION 33
GLOSSARY 35
ADDITIONAL DOCUMENTS 40
Sample Claim File Request Letter 40
Sample UM Appeal Letter 41
Sample Administrative Appeal Letter 42
Sample Representative Authorization Letter 43
Personal Statement 44
SUGGESTIONS FOR PROVIDERS: WRITING THE APPEAL OR A LETTER OF SUPPORT 45
CONTACT LIST 48

HOW TO USE THIS GUIDE

The purpose of this guide is to help people who are denied health insurance benefits to which they believe they are entitled. The guide is primarily addressed to those persons who receive health insurance under a group or individual health plan that is regulated by the State of New Jersey. However, whether your health insurance is a fully insured group plan or individual plan (that are both regulated by the State), purchased on or off the exchange, subsidized or unsubsidized by the federal government, or whether you receive health insurance through a large employer plan that is self-funded, you are a state or federal employee or you receive Medicaid or Medicare, the advice and forms in this packet will help you understand what the insurance company is saying and how to respond. There is substantial overlap in the appeals processes applicable to the different types of insurance, especially since a significant number of government employees and Medicaid recipients are enrolled in private health care plans and under the Patient Protection and Affordable Care Act (the "ACA"), the internal and external appeals processes of insured and self-funded employment-based plans have nearly converged.

This guide is organized into chapters that show you how to analyze your situation, respond to a denial of coverage and then prepare and write an appeal of that denial if you deem it appropriate to do so. It also explains unique parts of the appeals process that are applicable to the different kinds of health insurance plans mentioned above.

- Chapter 1 covers understanding a denial and then preparing to write an appeal by gathering all the information you need to begin. This chapter provides general information that is applicable to filing all insurance appeals though employs definitions as used in state law.
- Chapter 2 covers writing the appeal and what happens afterwards.
- Chapter 3 covers issues, primarily timelines and procedures, specific to self-funded group plans (typically large employer and/or union plans), Medicare, Medicaid/NJ FamilyCare, and plans applicable to state and federal employees as well as veterans.

The information in this guide is current as of December 2015. While we have made every effort to make sure it is accurate, you should contact the New Jersey Department of Banking and Insurance for help with specific questions, including information as to which government agency may help you depending on the type of insurance plan under which you and your family are covered.

Please note: this information is not legal advice. The contents are intended for general purposes only.

CHAPTER 1: PREPARING AN APPEAL

What Is an Insurance Denial?

An insurance denial is a decision by the health insurance company to deny payment of a claim or authorization for a particular medical service or supply that you believe is covered under your plan or should be covered pursuant to state or federal law. Such refusal to make payment or authorize your receipt of medical service or supply is sometimes called an **adverse benefit determination**. This phrase is defined by state law and includes "a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit" based on grounds involving the carrier's exercise of medical judgment or on contractual grounds, including the carrier's decision to rescind your coverage.[1] When you receive medical services or treatment, or your primary care doctor refers you to a specialist, who will provide you with needed services, the treating physician or other health care provider will submit a prior authorization request (if appropriate) and/or a request for payment to your insurance company. Usually, the insurance company will authorize payment to the provider. It will send you a letter telling you the treatment, date of service, the service for which the insurance company will pay, and the amount of money the doctor may directly bill you for the requested service (based on the co-pay or co-insurance terms of your plan and/or whether you have satisfied your deductible). This letter is called the **Explanation of Benefits (EOB)**.

If your insurance company has decided to deny authorization or payment, the EOB should state the reason for such denial. If it does not do so, or you do not understand the reason, one should call the insurance company and request an explanation written in a manner that you are able to understand. An EOB that says insurance coverage is not authorized either because your plan does not cover the treatment or because it is not medically necessary is an insurance denial. You can appeal this decision. The EOB or denial notice must include information about how to appeal the denial. [2] Problems that you might want to appeal include a determination:

- that a particular kind of care, service or prescription is not covered;
- that your provider is not appropriately licensed to deliver the care requested;
- that a requested treatment is not medically necessary;
- that a requested treatment is experimental or investigational;
- that a request to obtain services from a provider who is not in your plan's network (because the company's network does not have any providers who are qualified, accessible and available to see you to perform medically necessary services) was not approved;
- that there has been a reduction or termination of a covered service that you have been receiving under your health insurance;

[1] "Adverse benefit determination" is defined in New Jersey's regulations. See N.J.A.C. §11:24A-1.2 (non-HMO plans) and N.J.A.C. §11:24-1.2 (HMO plans).

[2] Plans are required to provide information on internal and external appeals processes to those insured in writing at the time of coverage, when rendering an adverse benefits determination, and again following each stage of the appeals process. See N.J.A.C. §11:24A-3.5(b) (non-HMO plans) and N.J.A.C. §11:24-8.4(a) (HMO plans).

- that pre-authorization for the specialist services, otherwise covered, was not properly obtained;
- that you have still not satisfied your deductible or that your out-of-pocket maximum has been calculated so that you still owe money; or
- that your insurance coverage has been cancelled or you were not covered on the date of service.

In New Jersey, with respect to insurance plans regulated by the State, these appeals are divided into two categories: **Administrative denials** and **Utilization Management (UM) denials**. An administrative denial is a refusal to pay a claim or authorize a service based on specific provisions or limitations in your insurance plan or any other ground that does not involve the exercise of medical judgment. For example, denial of payment on the basis that you have not satisfied the cost-sharing responsibilities under your plan (and you believe that your deductible, coinsurance or out of pocket costs have not accumulated properly) is considered an administrative denial that you may appeal (but such appeal is not subject to the same internal appeal processes or the external review requirement as a UM denial). A UM denial, on the other hand, is when the insurance company refuses to pay a claim or authorize a service or supply because it has decided that the service, specific provider, or supply is not medically necessary to treat your illness or condition. The two types of insurance denials involve different procedures that will be discussed herein, although both involve filing a written complaint, known as "an appeal," with your insurance company.[3]

You may give your doctor, a lawyer, a friend, or any other person your written permission to file an appeal on your behalf. You may use the "Authorization to Represent" on page 43 of this guide to do so. You have the right to file an appeal in the language in which you are fluent.[4] Call your insurance company to find out if there are special procedures you should follow in order to file your appeal in the language in which you are most competent.

What Is Not an Insurance Denial?

Complaints about the way a service has been delivered (i.e., quality of care), provider directory deficiencies, your inability to access the insurance company through call centers and websites, or the failure of the insurance company to issue you an identification card or benefit book. If you have a complaint about your plan that does not involve a specific denial of or payment for treatment you may file what some insurance plans call a "grievance" with your health insurance company. Your insurance company can tell you more about its complaint process. But all complaints must be responded to within 30 days from receipt.[5] You may also submit a complaint to the New Jersey Department of Banking and Insurance. Although these

[3] The resolution of appeals brought by members or providers, on behalf of members, with respect to adverse benefit determinations based on "ineligibility, including rescission or the application of a contract exclusion or limitation not related to medical necessity" need not comply with the 2-stage internal and external appeal processes, otherwise required for adverse benefit determinations involving medical necessity (i.e., medical utilization appeals). N.J.A.C. §11:24-3.7(c) (HMO plans); N.J.A.C. §11:24A-3.5(a) and 3.6 (a) (non-HMO plans) (the 2-stage internal and external appeals process excludes challenges based on "eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity.").

[4] N.J.A.C. §11:24-8.4 (2)(e) HMO plans; 11:24A-3.5(h)(non-HMO plans)

[5] N.J.A.C. §11:24-3.7(a)(4) (HMO plans); N.J.A.C. §11:24A-4.6(a)(4) (non-HMO plans).

situations are not considered denials that you can appeal, the Department is committed to investigating all types of complaints regarding health care insurance coverage provided by plans regulated by the State.

Timelines (Applicable to State regulated plans)

Your insurance company must notify you of its decision to deny you benefits, either service or payment, in writing in a timely fashion. The time varies based on the nature of the request that you or your provider make. Health insurance plans or payers have "no later than 15 days" to respond to a hospital or physician's request for prior authorization if you are to receive inpatient hospital services or health care services in an outpatient or other setting.[6] In case of a request for authorization for services for a person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, the payer is to communicate the denial of the request or the limitation imposed on the request in a "time framework appropriate to the medical exigencies of the case, but no later than 24 hours" following the time the request is made.[7] If the payer fails to respond to a prior authorization request within the time frames established by law, then the hospital or physician's request is deemed approved. [8] Finally, since payers are required to remit payment for every insured claim submitted by a covered person or health care provider, "no later than the 30th day following receipt of the claim by the payer" or "no later than the 40th calendar day following receipt of the claim by the payer" if the claim is not submitted electronically,[9] your plan should inform you in writing that it is denying you treatment with respect to services or treatments you have already received within 30 days of receiving your claim for such benefits. [10]

You, or any provider acting on your behalf with your consent, may appeal any adverse benefit determination resulting in a denial, termination or other limitation of covered health services within 180 days of receipt of the denial.[11] In general, the insurance company has 30 days to respond to your appeal of an adverse benefit determination.[12] However, in the case of a UM appeal, the health plan has 10 days to respond to your initial internal appeal to the company, and 20 business days to respond to your second internal appeal (if required).[13] Therefore, depending on when you file your second level appeal, the time to resolve your entire internal UM appeal may be greater than 30 days. In cases involving urgent or emergency care, the company must complete its internal appeals processes within 72 hours.[14]External appeals, which are only available to persons who have received an UM denial, are subject to a 48 hour response time from receipt of the appeal in the event of urgent or emergency care or where the standard review time "would seriously jeopardize the life or health of the covered person or jeopardize the

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[6] N.J.S.A. 17B:30-52(a)(1) & (3).
[7] N.J.S.A. 17B:30-52(a)(2); But see N.J.A.C. §11:24-8.3 (c)(1)(i)(HMO urgent care claim must be determined no later than 72 hours after receipt); 11:24A-3.4(d)(3)(same for non-HMO plans)
[8] N.J.S.A. 17B:30-52(c)
[9] See various provisions of N.J.S.A. 17B:30-48 et seq. (the Health Claims Authorization, Processing and Payment Act) applying to different payers.
[10] See also N.J.A.C. §11:24-8.3 (c)(1)(iii)(HMO plans must make determination concerning a post-service claim no later than 30 days of receipt); 11:24A-3.4(d)(3)(same for non-HMO plans)
[11] N.J.A.C. §11:24-8.4 (a)(HMO plans); 11:24A-3.5(a)(non-HMO plans)
[12] N.J.A.C. §11:24-3.7(a)(4)(HMO plans); 11:24A-4.6(a)(4)(non-HMO plans)
[13] N.J.A.C. §11:24-8.5 and 8.6 (HMO plans); 11:24A-3.5(j) and (k)(non-HMO plans)
[14] N.J.A.C. §11:24-8.5 and 8.6(HMO plans); 11:24A-3.5(j)(1)(i) and (k)(3)(non-HMO plans)

covered person's ability to regain maximum function."[15]Otherwise, the independent entity reviewing your external appeal has 45 days to consider your request to reverse the insurer's final determination (which it rendered as a result of the internal appeal process).[16]

Getting Organized

The first question you should ask yourself concerns the nature of the plan under which you receive health benefits, the name of the plan and the insurance company that either funds the plan itself (*i.e.*, fully insured plan) or administers it on behalf of a large employer, including government, who bears the risk of providing you with health benefits (*i.e*., self-insured plan). In New Jersey, you should be able to ascertain that information from the face of your insurance identification card. If you or your small employer bought the plan on the federal exchange, your card should clearly state "Fully-Insured" or "Insured by X Insurance Co." On the other hand, if you receive your insurance through your employer who did not purchase the plan on the exchange but rather funds the plan itself, your card will then say something like "Self-Insured," "Self-funded" or "Administered by X Insurance Company." If you receive health service benefits through government entitlement programs, such as Medicaid, Medicare or the Veterans Administration, your card will say "Medicare A & B," "VA Health Benefits, "TRICARE" or, in the case of NJ FamilyCare recipients or government employees, it will indicate the managed care company in which you enrolled. If you cannot identify the nature of the plan under which you and your family receive health benefits, call the phone number that appears on your card and ask the person answering the phone whether your plan is self-insured or fully-insured and whether it was issued in New Jersey. You may also pose this question to the human resources department of your employer, if applicable. Once you have this information, you can figure out how to appeal any adverse benefit determination that you have received.

We strongly suggest that you keep all the documents you receive from and send to the insurance company or your provider concerning the claim you would like to appeal in one file or location. Save all the information your insurance company sends you, and to the extent possible, make a copy for yourself to keep of every document you send to your insurance company. Important documents to include in your file are:

- The EOB letter or denial letter showing what payment or services were denied, including the insurer's explanation of why they were denied, and notice of your appeal rights.
- A copy of your request for an appeal that you sent your insurance company, or a note to yourself of the date on which you made an oral request for an appeal and the name of the person with whom you spoke.
- Any documents with additional information that you sent to the insurance company (such as a letter from your doctor or medical records).
- A copy of the Authorization to Represent (see sample in Appendix at pg. 43), if you choose to have your doctor or anyone else file the appeal for you. (You will need to send the original to the insurance company.)
- Notes from any phone conversation you have with your insurance company or your doctor that relates to your appeal. Be sure to take down the name and title of the person with whom you speak. Include the date and time of the conversation.

[15] N.J.A.C. §11:24-8.7(i)(1) (HMO plans); 11:24A-3.6(i)(non-HMO plans)
[16] N.J.A.C. §11:24-8.7(i) (HMO plans); 11:24A-3.6(h)(non-HMO plans)

Understanding Your Insurance Plan

As preliminary matter, you should take the time to carefully read the EOB or denial letter so you can get a better understanding of what service, treatment or payment the insurer denied and the reasons supporting that denial. To help you understand the insurance company's reasons, request a copy of the medical utilization standards or criteria the company employed when deciding to deny your claim, explanation of any diagnostic or treatment codes it used, and copies of any documentary evidence, including medical records or additional medical assessments, on which the company based its denial. All of this information is in your claim file, and should be provided to you free of charge by your insurance company (see Sample Claim File Request Letter in Appendix at pg. 40). Use all of this information to help you figure out the insurance company's rationale for denying you benefits you believed should be covered.

Once you understand the denial letter, you should also read your insurance plan documents. They may be on the insurer's website. If not, call your insurance company and request a copy of your plan and any riders that apply (riders change your benefits from those offered in the plan). Be sure to ask for the entire plan and not just a summary. This document may be called the Member Handbook, Benefits Handbook, or Evidence of Coverage. You are looking for the most comprehensive information that is available. Also, request the plan/handbook that was in effect at the time your claim was made. Once you have the right plan, try to read the portions of the plan that are relevant to your claim carefully. These documents may be intimidating, but one should try to understand whether the service or treatment that you requested is in fact covered or is subject to an exclusion or limitation in your contract.

Understanding the terms of your plan will assist you in determining whether you should be filing an administrative appeal or a utilization management (UM) appeal. For example, if your plan only permits 20 visits to a chiropractor, or 30 sessions with a psychologist or counselor, and you believe you need more sessions, you must file an administrative appeal and explain why you think the limitation in the plan should not apply. Similarly, if you believe you were insured at the time you received treatment and the plan disagrees, explain why you think you were insured. On the other hand, if your physician recommends surgery for a particular ailment you have and the insurance company denies payment for that surgery because it deems the treatment "not medically necessary," you must file a UM appeal. Denial of a request to visit an out-of-network physician, because the company's network does not have any providers who are qualified, accessible and available to treat you is also considered a UM denial. This is the case because the plan is exercising its medical judgment when it denies you the right to see an out-of-network physician under those circumstances. If you are unsure whether your dispute with the insurance company is administrative in nature or is a function of the company's utilization management criteria call the insurance company customer service or appeals division and ask. If you are still unsure, file the appeal with the company, and it will determine which track your appeal will follow.

In any event, there are also government agencies that will help you if you have difficulty getting a copy of your plan from the insurance company. If you have employment-based insurance, you may also request the plan from your employer if the insurance company does not provide it to you. If you have trouble getting it from your employer, call the U.S. Department of

Labor's Employee Benefits Security Administration at 1-866-444-3272. If you are having trouble getting a copy of the plan and it is an individual (also known as a non-group) health plan, call the New Jersey Department of Banking and Insurance at 1-609-292-5427. If you are having trouble getting a copy of the plan and it is an NJ FamilyCare managed care plan, call NJ FamilyCare at 1-800-701-0710. If you receive Medicare and/or Medicare Advantage and cannot get a copy of the plan, call the State Health Insurance Assistance Program at 1-800-792-8820 or 1-800-MEDICARE. State employees may call the State Health Benefits Commission/School Employees' Health Benefits Commission at 1- 609-292-7524 (7:30 a.m. to 4:30 a.m. to speak with a representative; automated information system available at all times); federal employees may call the Office of Personnel Management, Federal Health Insurance at 1-202-606-1234; and veterans, military personnel and retirees may call the Veterans Health Administration, Health Care Benefits at 1-877-22-8387.

When reviewing your plan, you should pay particular attention to the following:

- If you receive insurance through your employer, you must determine whether the plan is fully-insured (*i.e.*, the insurance company issuing the plan bears the risk of insurance), as is the case if your employer bought a small group plan on the federal exchange, or the plan is self-insured (*i.e.*, your employer bears the risk of insurance either alone or as a member of a multiple employer welfare arrangement—a MEWA);[17]
- All of the terms that appear in your denial and the plan's definition of each, such as "medically necessary," "excluded," "experimental," "unproven," "uncovered," etc.;
- The sections of the plan relating to the denied service; for example, if you were denied mental health treatment, be sure to review the plan's mental health services section;
- How to request your claim file, including the utilization standards and criteria that applied to your medical service or treatment and other records relating to the denial, all of which should be available to you at no charge;[18]
- What the plan says about your right to appeal administrative denials or UM denials, including the deadlines for filing the appeals, and where the appeals should be sent; and
- The options available to you, if any, if your internal appeals are not successful.

Read the information about appeals carefully. First determine whether your challenge to the insurer's adverse benefit determination constitutes an administrative denial. If so, follow the

[17] In 1983, Congress established a special exception to ERISA's preemption provisions for MEWAs. This exception was intended to eliminate claims of ERISA-plan status and Federal preemption as an impediment to State regulation of MEWAs by permitting States to regulate MEWAs that are ERISA-covered employee welfare benefit plans. Accordingly, in general states may regulate MEWAs that are fully-insured plans, and self-insured plans to the extent that such regulation does not violate Title 1 of ERISA, which includes consumer protections. For purposes of this Guide concerning insurance appeals, we will treat fully-insured MEWA plans as regulated by DOBI, and self-insured MEWA plans as subject to the appeal requirements imposed on other ERISA regulated plans. In either case, insurance plan documents should inform you of your appeal rights and how to proceed.

[18] It is important to note that pursuant to N.J.A.C. § 11:24-8.1(b) (HMO plans) and N.J.A.C. § 11:24A-2.1(b) (non-HMO plans), UM criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to members and participating providers in the relevant practice areas. The final federal parity rules also impose a general requirement that individual and small group plans must make available "[t]he criteria for medical necessity determinations. . . with respect to mental health or substance use disorder benefits . . . to any current or potential participant, beneficiary, or contracting provider upon request." 45 C.F.R. §§146.136(d)1;147.160(a).

procedure in the handbook for filing such appeals. If you are contesting a decision made by the insurance company involving a medical judgment that your treatment is not medically necessary or a decision to deny your request for an in-network exception, follow the procedures in the handbook for filing UM appeals. With respect to UM appeals, persons covered under an individual health plan must submit one internal appeal prior to seeking an external review; in contrast, persons covered under a small group plan must first file two internal appeals prior to seeking review by the designated independent entity. Appeals typically can be submitted either over the phone or in writing. As previously noted, we strongly encourage you to submit your appeal in writing (a copy of which should be retained in your files).

Requesting Your Claim File

An essential step in preparing your appeal is to write to the insurance company for a copy of your claim file. As noted previously, the claim file includes the medical utilization standards and criteria that the insurer applied to your case to support denial of your claim (including diagnostic and treatment codes and their corresponding meanings). To appeal a denial successfully, you must first understand the basis for it. This basis, along with all the other documents pertaining to your claim, will be in the claim file. The denial letter from your insurance company should explain how to request a copy of the claim file at no charge. If there is no information in the denial about how to do so, call your insurance company and ask about it.

It is important to request the claim file in writing. Keep a copy of this request so that you know when it was submitted. In your letter requesting your claim file, you should:

- Include a disclaimer that "this is not an appeal," because sometimes a claim file request is mistaken as an appeal;
- Include your name, address, phone number, the date you are sending the request, and refer to the EOB/denial letter (a copy of which should be enclosed);
- If sent by mail, send it by certified mail, return receipt requested;
- If faxed or e-mailed, confirm the fax number or e-mail address where the request should be sent;
- Include the patient's name, the member's name (if different from the patient), insurance identification number, the service that was denied, the date of the denial, and the treating doctor's name;
- State that the purpose of the letter is to request all information relevant to the denial;
- As noted above, include a copy of the EOB or denial letter (do not send the original); and
- Provide the address to where the requested claim file should be sent.

There are government agencies that will help you if you have difficulty getting your claim file. If you have employment-based insurance and do not receive a response to your claim file request within 30 days, call the United States Department of Labor's Employees Benefits Security Administration at 1-866-.444-.3272. If you have trouble getting the claim file from an individual (non-group) health plan, call the New Jersey Department of Banking and Insurance at 1-609-292-5427. If you have trouble getting the claim file from an NJ FamilyCare plan, call NJ FamilyCare at 1-800-701-0710. If you receive Medicare and/or Medicare Advantage and cannot get a copy of your claim file, call the State Health Insurance Assistance Program at 1-800-792-8820 or 1-800-MEDICARE. State employees may call the State Health Benefits

Commission/School Employees' Health Benefits Commission at 1- 609-292-7524 (7:30 a.m. to 4:30 a.m. to speak with a representative; automated information system available at all times); federal employees may call the Office of Personnel Management, Federal Health Insurance at 1-202-606-1234; and veterans, military personnel and retirees may call the Veterans Health Administration, Health Care Benefits at 1-877-22-8387.

Talk to Your Doctor

Ask your doctor or someone in your doctor's office for any information and medical records that might support your appeal. Provide a copy of the denial notice if they have not received it. Decide whether you want to ask your doctor to submit the appeal on your behalf. If your doctor agrees to do so, make sure s/he understands what is required.

In the Appendix, we have included Suggestions for Providers, found on pages 44-46, which will assist your health care provider if he/she decides to submit an appeal on your behalf or decides to write a letter of support, which you may submit with your appeal.

CHAPTER 2: WRITING YOUR APPEAL AND WHAT HAPPENS NEXT

After you have reviewed the EOB/denial letter you received and your plan contract or handbook, have obtained the claim file, have talked to your healthcare provider, and have collected your medical records and letters of support from your provider(s), it is time to start writing your appeal.

Suggestions on How to Write Your Appeal

Your appeal should identify the insurance company decision that you are appealing. It should clearly explain the reasons you believe that the decision to deny you benefits, services or payment should be reversed. In the case of an administrative dispute, identify the contract provision or limitation that you think has been inaccurately or inappropriately applied, and supply any documentation, including previous bills, relevant information from your provider or any other material you think is relevant to making your claim that the benefit or payment should be provided. In the case of an UM denial, you should focus your efforts on providing information, preferably from your treating physician or other providers, which supports your position that the service requested or already provided was medically necessary for your health. Stick to the facts of your case, and try not to include information that is extraneous to your appeal. In your appeal letter, be sure to:

- Include your name, address, phone number, and the date; if orally transmitted, keep notes of the date and the person with whom you spoke.
- Send the written letter by certified mail, return receipt requested.
- Make sure you are sending the appeal to the right place. Information on where to send it should be in the EOB/denial letter and the plan handbook. If not, call your insurer and confirm.
- Include the member's name (if it is not you), the insurance policy identification number, the group name (if you receive insurance through your employer or other association, such as a union or professional organization of which you are a member), the type of plan you have (such as fully-insured plan from your employer, Medicaid/NJ FamilyCare Plan, State Health Benefits plan and the like), and the name and professional identification number of the health care provider who provided the service or requested pre-authorization.
- Start with the exact language of the denial, including the particular treatment, and the date it was denied.
- Quote directly from the denial letter with respect to the reasons given for the denial. If numerical codes were provided, include them, in addition to any explanation provided in layman terms.
- If the insurer provided utilization standards of criteria it employed, include those criteria in your appeal. Similarly, if the insurer cited to particular provisions in your plan, including exclusions or limitations, include the language of those provisions in your appeal.
- Include a copy of the denial (EOB) (be sure not to include the original).
- List the reasons why you think that the adverse benefit determination should be reversed. In the case of a UM denial, state the reasons you satisfy the utilization standards that apply under your plan, and make sure you address each requirement separately. In the

case of an administrative denial, state the reasons why you believe the contract exclusion or limitation does not or should not apply or why a payment calculation is inaccurate or why you believe that you were covered on the day of treatment. Try to be as clear as you can and provide reference to any supporting documentation you have enclosed, including your medical records, if appropriate.

- Itemize in the letter each document that you are enclosing with the letter, and on which you are relying.
- **Among the documents included should be a doctor's letter of support, if appropriate to the denial**.
- Provide copies of all the relevant medical records, if appropriate to the denial.
- **Include a separate personal statement about what this treatment means to you, your medical condition, and your day-to-day living, which should be summarized in your letter.**

Once you have finished writing your appeal letter, it is suggested that you try to get some feedback about the letter prior to submitting it. Ask someone you know, such as a family member, close friend, or your doctor to read your appeal. Ask them whether you have convinced them that the insurer's denial was wrong. Do not be shy about asking for suggestions to improve the letter.

Before sending your appeal, make a copy of it and all of the documents enclosed. Be sure to send it certified mail, return receipt requested. This method allows you to know when your appeal was received.

You can authorize someone else to submit your appeal on your behalf. You will need to submit a signed authorization form to your health insurer that will permit communication with your representative on your behalf. This authorization is required even if it is a family member, parent, or spouse who is representing you. You can often find these forms on your health plan's website or by calling the customer service phone number on your member identification card. A sample authorization form is provided in the Appendix on page 43, but it is best to check with the health insurer in case it requires its own specific authorization form.

If you need assistance submitting an appeal with respect to a fully-insured, private insurance plan, issued in New Jersey, you may call the NJ Appleseed at 1-973-735-0523 or New Jersey Citizen Action at 973-643-8100. Our respective staffs are able to answer your general questions about the appeals process. We will also talk with you to determine if we are available to provide direct assistance to you with your appeal. If you are covered by insurance issued in a state other than New Jersey, you may be able to identify resources that are available to help you with your health insurance appeal questions at www.healthcare.gov/how-do-i-appeal-a-health-insurance-companys-decision/.

What Happens Next? Internal Appeals

As noted throughout this Guide, adverse benefit determinations give rise to two different types of appeals: Administrative appeals and UM appeals. Both must be filed within 180 days of your receipt of the denial, and the insurance company has 30 days to decide an administrative appeal, and a total of 30 days, not necessarily sequentially, to decide an UM appeal (*i.e.,* 10 calendar days to respond to the initial UM appeal, and 20 business days to decide a second level internal appeal), unless the appeal involves a request for medical care that is deemed urgent. (see Timelines, at pp. 5-6)

Administrative Appeals. You or your authorized representative may appeal and request that your health plan reconsider any claim or portion(s) of a claim for which you believe that benefits have been wrongfully denied based on the plan's exclusions and/or limitations. Typical administrative appeals challenge the insurer's decision as to whether a particular service is covered or was paid appropriately. Examples include, but are not limited to, payment denied because prior authorization was not secured; provider was not an appropriately licensed provider; deductible was not satisfied; charges exceeded a limitation in the plan (such as a "reasonable and customary" allowance); visits to physician exceeded a numerical number; or treatment was provided when member was not enrolled. As detailed in Chapter 1, you should state the reason you think that your claim or request for services should be reconsidered in your appeal and enclose all documentation that you think supports your appeal.

Pursuant to regulations, the health plan must respond to your administrative appeal within 30 days. Some plans may offer you a second level administrative appeal. Where plans permit a second level internal administrative appeal, they may also permit you to submit additional information for their consideration if you so request. The law does not require plans to offer you this second level appeal. Notwithstanding, at the end of the internal administrative appeals process, you should receive a written final determination.

For most people, this is the end of the road unless you desire to seek further remedies in court. (If you are in this situation, you should consult with an attorney to help you decide whether that is a course of action you would like to take). For others, such as individuals enrolled in a Medicaid managed care plan or the NJ State Employees Health Benefit Plan there may be further recourse to administrative remedies. (See Chapter 3). In any event, if there are additional appeal remedies, they will be specified in the final written determination you receive from your health plan.

Utilization Management (UM) Appeals. You or your authorized representative may appeal and request that your health plan reconsider any claim or portion(s) of a claim for which you believe that benefits have been wrongfully denied based on the plan's exercise of its medical judgment. Typical UM appeals challenge the insurer's determination that a particular service or treatment was not medically necessary, did not meet medical policy criteria or was experimental. Pursuant to New Jersey regulations, UM appeals for persons enrolled in group plans entails a two-level internal appeal process followed by an external review by an independent entity, whereas persons covered under an individual contract are only required to file one internal appeal before requesting such external review. Under some circumstances, you may be relieved of your obligation to complete the internal review processes, such as when you plan has

expressly waived its right to an internal review or when you apply for an expedited external review at the same time as you apply for an expedited internal appeal[19] (in the situation where the initial adverse utilization management determination involves a medical condition that the completion of the standard appeal processes would jeopardize your life or health); however, in the usual case the internal appeal process proceeds as follows:

You may submit your first and second level UM appeals in writing or verbally. However, as we stated in the previous chapter, it is best if you do so in writing. As part of your first stage appeal, you, your provider and or your authorized representative must be given the opportunity to speak to your plan's medical director and/or his physician designee who rendered the adverse benefit determination denying your treatment in addition to submitting your appeal letter.[20] This stage of your appeal is considered to be informal. Hopefully, your appeal will be resolved to your satisfaction at this stage. However, if it is not, your plan must render its decision within 10 calendar days (unless your case involves a request for urgent or emergency care that must be resolved within 72 hours). In addition, the plan, in its written determination, must inform you of your right to move to a stage 2 appeal (if you are covered under a group plan) or an external review (if you are insured pursuant to an individual health benefit plan), including telling you the time limits in which you must act and to whom it should be addressed.[21]

In a stage 2 appeal, considered to be a more formal process, you, your provider and or your authorized representative **must resubmit your appeal letter (with documents) to a panel of physicians and/or healthcare professionals selected by your insurance plan so long as those persons were not involved in the UM denial that you are appealing**.[22] You, your provider and or your authorized representative are permitted to participate in a hearing with this panel either in person or by phone, and you are permitted to provide additional or new information in support of your case, if you obtained such information after you filed your initial appeal. Stage 2 appeals must be filed within 180 days of Stage 1 denials[23], and must be concluded in no more than 20 business days, unless a request for urgent or emergency care is involved (in which case it must be completed in no more than 72 hours). The insurer must also acknowledge receipt of your request for a level 2 appeal within 10 business days of receipt of your second internal appeal.[24]

In any event, if the panel denies your appeal, your carrier must provide you with written notification of the denial and the reasons therefore together with a written notification of your right to proceed to an external review. That notice should also give you specific instructions as to how you may arrange for an external appeal, and should include any forms required to initiate such appeal.[25]

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[19] N.J.A.C. §11:24-8.5(f) (HMO plans); 11:24A-3.5(l)(non-HMO plans)
[20] N.J.A.C. §11:24-8.5 (HMO plans); 11:24A-3.5(j)(non-HMO)
[21] N.J.A.C. §11:24-8.5 (HMO plans); 11:24A-3.5(j)(2)(non-HMO))
[22] N.J.A.C. §11:24-8.6(a) (HMO plans); 11:24A-3.5(k)(non-HMO)
[23] NJ Department of Banking and Insurance, Appeal and Complaint Guide for New Jersey Consumers, p.2.
[24] N.J.A.C. §11:24-8.6(c) (HMO plans); 11:24A-3.5(k)(non-HMO)
[25] N.J.A.C. §11:24-8.6(e) (HMO plans); 11:24A-3.5(k)(4)(non-HMO)

It should be noted that your insurer must continue to provide coverage of an ongoing course of treatment that you have been receiving pending the outcome of all internal appeals and the external review involving that treatment.[26]

Requesting an External Review

If you are not satisfied with the resolution of your internal appeals with respect to your UM appeal, you may appeal the final internal decision, which you received, through the Independent Health Care Appeals Program (IHCAP) to an independent utilization review organization (IURO).[27] A request for this external review must be filed within four months of your receipt of the insurance company's final decision on your internal appeals.[28] To make such request, you, your provider or authorized representative must complete the form found at www.state.nj.us/dobi/division_insurance/managedcare/ihcap.htm. The completed form, together with a $25.00 filing fee (that may be waived for persons who demonstrate financial hardship),[29] and "a general release executed by you for all medical records pertinent to the appeal"[30] should be mailed to:

Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ
(888) 393-1062

You should also include with you request for an external review all the information you submitted to the insurance company as part of your internal appeals, any additional information you want the IURO to consider,[31]and a copy of the insurance company's initial UM denial and its decision(s) on the internal appeal(s).

Once your request has been received, the New Jersey Department of Banking and Insurance will assign your appeal to an IURO for review, which in turn will refer your appeal to a physician in the appropriate specialty. The IURO, after a preliminary review of your application (to determine whether (i) you are a covered person under the plan, (ii) the treatment you are requesting appears to be covered under the plan, and (iii) you have submitted all the information that is required to be provided)[32] will notify you within 5 business days after receipt of your external appeal, whether it has been accepted for processing. Once accepted, the IURO must complete its review and make a determination as soon as possible in accordance with the medical exigencies of the case, a time period that cannot exceed 45 days from receipt of your request for an IURO review.[33] As is the case concerning internal appeals, an external appeal

[26] N.J.A.C. §11:24A-3.5(i)(non-HMO)
[27] N.J.A.C. §11:24-8.7(a) (HMO plans); 11:24A-3.6(a)(non-HMO)
[28] N.J.A.C. §11:24-8.7(b) (HMO plans); 11:24A-3.6(b)(non-HMO)
[29] N.J.A.C. §11:24-8.7(c)(2) (HMO plans); 11:24A-3.6(c)(2)(non-HMO)
[30] N.J.A.C. §11:24-8.7(b) (HMO plans); 11:24A-3.6(d)(3)(non-HMO)
[31] N.J.A.C. §11:24-8.7(f)(HMO plans); 11:24A-3.6(e)(non-HMO)
[32] N.J.A.C. §11:24-8.7(f)(HMO plans); 11:24A-3.6(d)(non-HMO)
[33] N.J.A.C. §11:24-8.7(i)(HMO plans); 11:24A-3.6(h)(non-HMO)

that involves care for an urgent or emergency situation or involves a medical condition for which the standard review time would seriously jeopardize your life or health or your ability to regain maximum function, the IURO must complete its review within no more than 48 hours following receipt of your appeal. [34]

In any case, one should be aware of the fact that the IURO is authorized to consider all pertinent medical records and documents submitted by you and the carrier, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, as well as any applicable clinical protocols or guidelines developed or used by the carrier.[35]

The decision of the IURO is binding on the insurer and you, except if other remedies are available to you under state or federal law. If you are dissatisfied with the decision of the IURO, you should consult with an attorney to determine whether you have further recourse in the courts, or have any other administrative appeals available to you. In any event, if the decision is in your favor, your health plan must refund the $25.00 filing fee to you.

[34] Ibid.

[35] N.J.A.C. §11:24-8.7(g)(HMO plans); 11:24A-3.6(g)(non-HMO)

CHAPTER 3: SPECIAL CONCERNS BASED ON TYPE OF PLAN

If you are insured through an individual, small employer or other group health plan that is regulated by the State of New Jersey, the appeals process set forth above applies without any modification. However, if you are insured through a group plan that is self-funded (typically a large employer-based plan), Medicaid/NJ FamilyCare, Medicare, the State Employee Health Plan, the Federal Employee Health Plan, or a health benefits plan available to you through the Department of Veterans Affairs, there may be other applicable procedures that you should follow. This chapter provides some basic facts about those differences. It also lists the places to go for more help. All of the advice in this guide set forth in Chapters 1 and 2 about the collection and use of information connected to your appeal nonetheless remains important for these kinds of insurance plans or health benefit programs.

Employment-Based Self-Funded Plans

A significant number of New Jerseyans receive health insurance through their employment or the employment of their spouse. Some of those plans, if fully-insured (*i.e.,* coverage is provided by licensed insurance companies), are subject to state insurance law, including state law on appeals from UM denials as delineated in Chapter 2. However, a majority of those who receive health benefits as an incident of their employment are covered by self-funded plans, which are not subject to state regulation.[36]These plans are governed by ERISA, and are subject to regulation by the U.S. Department of Labor.[37]

ERISA provides a covered member with the right to a "full and fair review" of the denial of their claim for coverage or payment.[38] This means, first, in the event of an adverse benefit determination, the plan must provide the beneficiary with a **notice of denial** that must specify (1) the particular reasons for the denial; (2) specific reference to the provisions of the plan on which the denial is based; (3) an explanation of additional information that would permit the claim to move forward, including why that information is necessary; and (4) a description of the plan's review process, including any time limits imposed, including the steps you must take if you want your claim reviewed. **This review process of an employee benefit plan must afford its beneficiaries** (i) 60 days following notice of an adverse determination to appeal the decision; (ii) the opportunity to submit additional information relating to their claim; (iii) reasonable access to all documents and records related to their claim;[39] and (iv) an additional review that takes into account all documentation, regardless of whether it was included with the original claim.[40] The claims procedures of a group health plan, however, must comply with the requirements of

[36] The extent of the authority of the state to regulate MEWAs with respect to the appeal process is beyond the scope of this Guide. Persons who receive their insurance through a self-funded MEWA should follow the appeals procedures set forth in their plan's handbook and consult with an attorney.
[37] 29 U.S.C. §1144(b)(2)(B)
[38] 29 U.S.C. §1133

[39] Such documents include the "instruments under which the plan is established," 29 C.F.R. §2560.104(b); instruments include information on medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an "NQTL", which is a limitation on scope or duration of benefits for treatment that is not expressed numerically. Mental Health Parity FAQs, Part 31, at 12, Q.8.
[40] 29 C.F.R. §2560.503-1(h)(2)(i)-(iv)

(ii)-(iv) listed above, but must also (1) provide beneficiaries 180 days following notification to appeal a decision; (2) provide for a review that does not afford deference to the initial determination and that is conducted by an individual, independent from the original determination; (3) provide that the named fiduciary conducting the secondary review will consult a medical professional; (4) identify the medical experts whose advice was obtained in connection with the decision; and (5) ensure the medical professional consulted regarding the appeal is independent of the original determination.[41] Under ERISA, you must complete all the steps provided to you by your plan before filing a complaint against the insurer in court.

So, what appeal procedures are required of employment-based self-funded plans? Under current federal regulations, employment-based plans are required to provide written or electronic notification of any adverse benefit determination; permit claimants to present evidence and testify in support of their claims; provide unbiased decision-makers; and make timely decisions, with the reason for the decision clearly stated, in addition to notice of the availability of an additional external review.[42] The requirement for self-funded plans (which are not grandfathered by the ACA) to provide claimant's the opportunity for an external appeal is the major change rendered by the ACA. Now, in order to comply with the ACA's expanded mandate, self-funded plans must adopt one of two options: they must "voluntarily comply with the external review procedures applicable to insured plans in the state in which the issue arises or comply with standards and procedures set forth in the Technical Guidance promulgated by the DOL.[43] The requirements set forth in the Technical Guidance are substantially similar to the requirements for insured employment-based plans in New Jersey as described in Chapter 2. In this way, in New Jersey, the internal and external appeals process for UM denials of insured and self-funded employment-based plans have nearly converged. It is just that if you want to complain about your insurer you must file such complaint with the DOL, not NJ's DOBI.

Medicaid/NJ FamilyCare

In New Jersey, medical services received pursuant to the federal/state Medicaid program are provided under the name "NJ FamilyCare."[44] Eligibility is based on household income. Children, disabled persons, parents or other relatives who serve as caretakers, pregnant women, and single adults all may qualify for NJ FamilyCare. If you have employment-based insurance or are a documented immigrant who has not resided in the State for at least 5 years, however, you are not eligible for Medicaid. Eligible individuals may enroll in NJ FamilyCare online, by mail, or in person at a county enrollment site. Call 1-800-701-0710 or go to www.njfamilycare.org for more information with respect to the enrollment process.

If you are covered by Medicaid or NJ CHIP (both of which constitute NJ Family Care), and your claim for medical assistance has been denied or is not acted upon with reasonable promptness, you have the right to appeal that decision. The appeal process that is available to you, however, is dependent on whether you are a Medicaid-Plan A or ABP, or NJ CHIP Plan B,

[41] 29 C.F.R. §2560.503-1(h)(3)(i)-(v)
[42] See 29 C.F.R. §2590.715-2719(b)
[43] DOL TECHNICAL RELEASE 2010-01, at 2-3 (August 23, 2010)
[44] "Medicaid" means the program administered by the NJ Division of Medical Assistance and Health Services Program in the NJ Department of Human Services, providing medical assistance to qualified applicants in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

C, or D, beneficiary and/or whether you are enrolled in a managed health care plan. The name of the plan under which you are enrolled should appear on the face of your Medicaid card.

Under New Jersey's regulations, NJ Family Care-Plan A beneficiaries and NJ Family Care Plan D parents with incomes up to 133% of the federal poverty level have the right to request what is called a "fair hearing" if their claim for medical assistance is denied or is not acted upon with reasonable promptness.[45] Such beneficiaries may also file for a Fair Hearing if they have been harmed by any other action taken by the Medicaid agency that results in a determination of "non-eligibility, denial, termination, reduction or suspension of such assistance."[46] Such requests for a Fair Hearing must be made within 20 days from the date one receives notice of the adverse decision by your Medicaid Agent or NJ Family Care Program, and must be in writing.[47] The address to which one must file the request for the Fair Hearing should be included in the notice of the adverse decision. Federal and state law require that Medicaid beneficiaries or their representatives have the right to "examine at a reasonable time before the date of the hearing", "the content of [their] case file" and all documents the State agency or its agent intends to use at the hearing.[48]

On the other hand, under similar circumstances, NJ Family Care-Plan B, C, and other Plan D beneficiaries are only afforded the opportunity to file a "grievance" with the NJ Family Care-Children's Programs, at P.O. Box 8367, Trenton, NJ, 08650-9802; that grievance, however, may include a request for a hearing (not a formal "fair hearing") in the event that you believe that medical services were improperly denied.[49] The grievance procedure involves an initial review by a Grievance Counselor and a review and written decision by the Grievance Review Board ("GRB"), if requested. The review process must be completed within 60 days, and there is no opportunity for oral participation by the beneficiary.[50]

In 2015, most NJ Family Care recipients in NJ receive their health benefits through one of five private health care (managed care) companies: Amerigroup, Healthfirst NJ, Horizon Blue Cross Blue Shield, United Healthcare, and WellCare. (However, mental health services are carved out of those plans, and remain provided to Medicaid recipients on a fee-for–service basis). Accordingly, with respect to services covered under those plans, a Medicaid beneficiary who is a member of a managed care organization may file an appeal of an adverse benefit determination directly with the managed care company pursuant to its internal appeals processes (**in addition** to the right to request a Medicaid Fair Hearing if they are NJ Family Care-Plan A beneficiaries and NJ Family Care Plan D parents with incomes up to 133% of the federal poverty level).[51] It is especially important to note that enrollees of certain NJ FamilyCare plans that do not have access to the Fair Hearing process described in N.J.A.C. §10:49-10, are accorded all the

[45] N.J.A.C. §10:49-9.14(Provisions for appeals; fair hearings)
[46] N.J.A.C. §10:49-9.14(c)
[47] N.J.A.C. §10:49-10.3(b)
[48] 42 C.F.R. §431.242. See also N.J.A.C. §1:10B-10.1(a), §10:69-6.10, and §10:71-8.4.
[49] N.J.A.C. §10:79-6.5(b)
[50] N.J.A.C. §10:78-8.1 to §10:79-6.6.
[51] See N.J.A.C. §10:74-11.1(a)(requiring managed care company to establish a grievance procedure for the receipt and adjudication of any and all complaints from enrollees relating to quality, scope, nature and delivery of services); N.J.A.C. §10:74-11.2(requiring contractor to ensure that all Medicaid and NJ FamilyCare-Plan A and Plan D adult enrollees with incomes under 134% of the FPL are informed of their rights to a Fair Hearing)

appeal rights consistent with the appropriate rules established by the Department of Banking and Insurance applicable to state regulated plans, as described in Chapters 1 and 2. [52]

This means that for almost all Medicaid beneficiaries in New Jersey, the appeals process for all adverse benefit determinations may start out in the same way as it does for those persons covered by individual and small group plans regulated by the State. That is, if you are not entitled to a Medicaid Fair Hearing, you may still appeal the adverse benefit determination directly with your managed care plan, and if you are entitled to a Fair Hearing, you may also choose at the onset of the process to file your appeal with the insurance company, **even if at some later date you decide to request the Fair Hearing**. As noted in Chapter 1, there are administrative denials and medical utilization denials. Timelines for filing these internal appeals are set forth in the handbook governing you Medicaid managed care plan; the handbook will also tell you with whom you must file the appeal. [53]

It should be remembered that NJ FamilyCare-Plan A and NJ FamilyCare-Plan D parents with incomes of with incomes up to 133% of the federal poverty level still have the right to request right to ask for a Medicaid Fair Hearing when coverage has been denied, even if such individuals initially decide to file an appeal with the managed care company. You can ask for a Medicaid Fair Hearing in writing at any time during the internal and external appeals process, but no later than 20 days (with possible extension) after you have received notice of your insurance company's denial of your claim that gives rise to your request for a hearing.[54] This includes the managed care plan's decision to deny your internal appeal. A definitive and final administrative action must be taken within 90 days of your request for a fair hearing, except where you, the claimant, request an adjournment. [55]

In addition, as noted above, for those persons eligible for a Fair Hearing they do not have to begin the internal appeals process at all. They can go straight to a Medicaid Fair Hearing. If you choose that route, you will probably have less information about the reasons the company denied your claim or payment than if you file an internal appeal. Nonetheless, be sure to request your claim file from the insurance company when you file for a Fair Hearing just as you would if you were to file an internal appeal. As noted above you are entitled to examine documents on which the State or, its agent, the managed care company will rely.

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[52] N.J.A.C. §11:24-8(internal and external appeals).

[53] PLEASE NOTE: In May, 2015 CMS issued a proposed rule regarding Medicaid and CHIP Managed Care programs, which includes specific provisions regarding grievances and appeals. CMS-2390-P. The proposed rule would align time frame for appeals so as to make them more consistent with the private market. The rule would require all states **to offer a 60-day time period to request an external review through the fair hearing process (which is longer than New Jersey currently allows**), and would make clear a beneficiary's right to access her file, medical records and other documents used by the insurer to make its coverage determination. The proposed rule would also require Medicaid recipients **to exhaust internal appeals procedures before seeking a fair hearing. This exhaustion requirement would present a significant change for New Jersey beneficiaries**.

[54] N.J.A.C. §10:49-10.3(b)(3)

[55] N.J.A.C. §10:49-10.9

With respect to a Medicaid Fair Hearing, one has the right to appear at the hearing, present evidence and cross-examine witnesses before an Administrative Law Judge (ALJ).[56] The ALJ is an impartial decision maker who follows the procedures set forth in the Administrative Procedure Act, the Uniform Administrative Procedure Rules and Special Hearing Rules that are applicable to beneficiary hearings.[57] You may request reimbursement for transportation costs to and from the hearing for you and your witnesses. In fact, if your condition prevents you from appearing at the hearing location, the hearing shall be scheduled at your current residence.[58] When the hearing involves medical issues, such as those concerning a diagnosis or an examining physician's report, the hearing officer may determine that it is necessary to have a medical assessment other than that of the person involved in making the original decision, and may require that such medical assessment be obtained at the DHS's expense.[59] At the Fair Hearing, you may be represented by a lawyer or any other person you choose. In order to request a Medicaid Fair Hearing, you must write a letter to the Division of Medical Assistance and Health Services at the address below and include a copy of the insurance company's denial letter:

Division of Medical Assistance and Health Services
Fair Hearing Section
P.O. Box 712
Trenton, NJ 08625-0712
Phone: 1-800-356-1561

The ALJ's decision may be modified, altered or reversed by the Director of the Division of Medical Assistance and Health Services (DMAHS) within 45 days after it is rendered. DMAHS' head shall specify the reasons for the decision and identify all evidence supporting it.[60] This is considered a final agency decision; so, if you disagree with the Director's final decision, you can appeal it to the Appellate Division of the New Jersey State Superior Court. Your appeal to the Appellate Division, however, rests solely on the documents and evidence presented to the ALJ and the Director below. However, since Medicaid involves a federal program, you may also have recourse in the federal courts with respect to your adverse benefit determination. You should consult with an attorney to determine what your options are before seeking further relief.

You may be able to secure assistance with respect to the Medicaid fair hearing process from Legal Services of New Jersey at 1-888-576-5529 or Community Health Law Project at 1-973-642-8871.

In addition, when you receive notice of denial of your benefits or proposed denial of coverage under Medicaid, check the notice to determine whether you have the right to make a request for continuing aid during the appeal or Medicaid Fair Hearing process. The notice will also inform you to whom and how you should apply for such aid. Usually, such a request will allow you to continue receiving services from your plan if:

[56] N.J.A.C. §10:49-10.6
[57] N.J.A.C.§10:49-10.8
[58] N.J.A.C.§1:10-9.2
[59] N.J.A.C.§10:49-10.7
[60] N.J.A.C.§10:49-10.12(a)

- The appeal is requested prior to the proposed reduction, suspension, or termination of a previously authorized service;[61] and
- The appeal is filed on time; and
- The service was ordered by an authorized provider.

You have 10 days after you have received the insurance company's or Medicaid Agent's letter denying you coverage or payment to make this request.[62]

Medicare

Medicare provides insurance to people 65 years of age and older and to some people below that age with disabilities. There are two main ways that people receive their Medicare coverage: Original Medicare (Parts A, Hospital Insurance and B, Medical Insurance) or Medicare Advantage (Part C).[63] Prescription drug coverage, Medicare Part D, is provided either through a stand-alone prescription drug plan (PDP) or a part of the benefit package of a Medicare Advantage plan (MA-PD. Some people, with Original Medicare, have additional coverage through Medicare Supplement Insurance (Medigap). New Jersey also has a Medicare Supplement program that is for persons who are on Medicare, but under age 50, and are enrolled due to a disability or end stage renal disease.[64] If you are unsure what type of coverage you have, check your red, white and blue Medicare card and check all other insurance cards you have. Call the phone number on the cards to get information about the specific services that are covered under your plan.

As in the case of state regulated insurance plans, all Medicare Plans distinguish between a complaint (also known as a grievance) and an appeal. One can file a complaint if one has a concern about the quality of care or other service you are getting from a provider. If one disagrees with a coverage or payment decision made by Medicare, your Medicare private health plan or your Medicare Prescription Drug Plan, one must file an appeal. Specifically, you have the right to appeal, if Medicare, your Medicare health plan, or your Medicare drug plan denies: a request for a health care service, supply, item, or prescription drug that you think you should be able to receive; a request for payment of a health care service, supply, item or prescription drug that you already received; or a request to change the amount you must pay for a health care service, supply, item, or prescription drug. You may also appeal if Medicare or your plan stops providing or paying for all or part of a health service, supply item or drug you believe you still need, and, if you have a Medicare Medical Savings Account (MSC) Plan and think you have met your deductible or you think a service should count toward that deductible.

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[61] 42 C.F.R. §431.230
[62] 42 C.F.R. §431.231
[63] A Medicare Advantage Plan is a type of Medicare health plan that is offered by a private company that contracts with the federal government to provide you with all the benefits you would receive under Part A and Part B of Medicare. These plans include Health Maintenance Organizations, Private Fee-for-Service Plans, Preferred Provider Organizations, Special Needs Plans and Medicare Medical Savings Account Plans. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Part D Prescription Drug Plans.
[64] N.J.A.C. §11:4-23A.1.

In addition to Medicare grievance and appeal rights, there are state agencies where you can file complaints about Medicare plans or providers. Any complaint you may have about a doctor, hospital or provider; a health or drug plan; quality of care; dialysis or kidney transplant care; or durable equipment must be filed with a specific agency, such as your State Survey Agency or your Beneficiary and Family Centered Quality Improvement Organization, depending on the nature of the complaint. Accordingly, you should contact your State Health Insurance Assistance Program (SHIP) for personalized help with making a complaint or consult Medicare's website (contact information noted below) to determine the exact place you should file your complaint given the specific nature of your grievance.

The appeal process is also not uniform in its details; rather it depends on whether you are appealing a decision by Medicare, your private Medicare health plan, or your Medicare prescription drug plan.[65] Though the different steps one may take as part of the appeals process for the three types of Medicare plans are similar, different timelines apply. For example, with respect to original Medicare appeals, one must file a request to reconsider a denial of payment or coverage within 120 days of receiving the Medicare Summary Notice in which that denial of payment or coverage appears. On the other hand, regarding private Medicare health plan appeals, one must file the request to reconsider an initial denial within 60 days of the date of the plan's denial determination.[66] Private health plans also have to respond to one's request to reconsider a denial within 30 days for a standard request for service, 60 days for a request for payment of services already received, and 72 hours if your physician has made an urgent request, because she believes that waiting for a standard decision may jeopardize your life, health, or ability to regain maximum functioning.

Despite different timelines governing these three appeal processes, they each entail a 5-step process.[67] Level 1 involves reconsideration by the plan (or government contractor in the

[65] As a preliminary matter, it should be noted that Medicare claims under Part A or B must be filed by those providing the service or supply no later than 12 months (or 1 full calendar) year after the date when the services were provided. One should check the Medicare Summary Notice (MSN) that each Medicare beneficiary receives every three (3) months to ensure that claims are being timely filed. If the claim does not appear on your notice, contact your doctor or supplier, and ask them to file a claim for the services you received. If it is close to the end of the 12 months, one should file the claim oneself. One can access the Patient Request for Medical Payment form (CMS-1490S) at http://medicare.gov/claims-and-appeals/file-a-claim/file-a-claim.html.

[66] You, your representative or your physician may ask a private Medicare plan in advance to make an initial decision to ensure that the services are covered. A decision should be received from the plan within 14 days unless your physician believes that an emergency exists and requests that such determination be made within 72 hours.

[67] If you have coverage either through a Medicare Special Needs Plan or Programs of All-inclusive are for the Elderly (PACE), your appeal rights are different. The SNP or PACE organization must tell you in writing how to file an appeal if you receive coverage under either of those plans.

case of original Medicare) of its initial decision. Level 2 involves an external review by an independent entity, under original Medicare that entity is called a Qualified Independent Contractor (QIC) and under private health plans it is known as an Independent Review Entity (IRE). Level 3 involves a hearing before an Administrative Law Judge (ALJ). The Medicare Appeals Council then reviews the decision given by the ALJ, at which time you are permitted to identify the parts of the ALJ's decision with which you agree or disagree. If one disagrees with the Appeal Council's decision in Level 4, one typically has 60 days to request judicial review by a federal district court (Level 5). At each level, you will be given information from your plan or the entity making the decision on when you will receive a determination and how to proceed to the next level.

For further and more detailed information about appealing a denial of coverage for a service or prescription while on Medicare, go to http://medicare.gov/claims-and-appeals/file-an-appeal/appeals.html. For help filing a complaint or appeal, call the New Jersey State Health Insurance Assistance Program at 1-800-792-8820, or go to www.state.nj.us/humanservices/doas/services/ship/. You can also get help from the Medicare Rights Center, which is located in Manhattan but assists consumers throughout the United States, by calling 1-212-869-3850, or by logging on to www.medicarerights.org. The Medicare Rights Center also has a great tool kit for health plan appeals that can be accessed at http://www.medicarerights.org/fliers/Rights-and-Appeals/OM-Post-Service-General-Appelas-Packet.pdf?nrd=1 .

Government Employees

New Jersey State Employees

Employees of the State of New Jersey receive their health insurance through either the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP). These programs, which are governed respectively by the State Health Benefits Commission and the School Employees Health Benefit Commission (the "Commission"), provide access to several state managed care plans that are provided by several private insurers.[68] Any member of the SHBP (and SEHBP) who disagrees with a decision by the claim administrator of the plan in which the member is enrolled may request that the matter be considered by the Commission, but only after all appeals "within" the plan are exhausted.[69] This means for appeals of decisions involving medical judgment, one must exhaust the two rounds of internal appeals and have, at minimum, requested your health plan to provide an external review prior to asking the Commission to consider your case. As is the case with private plans, you must submit a request to your carrier for an external appeal with an independent review organization within four (4) months from your receipt of the plan's final adverse benefit determination. If your plan, after a preliminary review, determines that your request was complete but not eligible for an external review, it will inform you of the reasons for its denial and you may contact the Employee Benefits Security Administration at 1-866-444-3272 if you have further questions.

[68] N.J.S.A. 52:14-17.26 (g)(state managed care plan, SHBP); N.J.S.A.52:14-17.46.2(i)(state managed care plan, SEHBP)
[69] N.J.A.C. §17:9-1.3(a).

Similarly, one must exhaust the plan's procedures for filing an administrative appeal, which disputes a denial of coverage based on a plan's benefit limits, exclusions or payment of services, prior to filing with the Commission. The plans do not provide an external review, however, of its administrative denials. A person who disagrees with a determination made by the Division of Pensions and Benefits regarding their enrollment or eligibility in the SHBP may also request that their matter be considered by the Commission.[70]

With respect to your right to file an appeal with the relevant Commission, you have one year from the receipt of your initial denial to ask the Commission to consider your case. This one-year limitation appears to be a requirement contained in the contracts between the health, prescription, drug and dental plans and the Commission,[71] and accordingly may be changed when the plan is reissued. Since it is not a creature of statute or regulation, please check your handbook to determine the exact time in which you have the right to appeal your denial to the Commission.

To file an appeal with the Commission, consider your appeal, you or your representative must write to:

Appeals Coordinator
State Health Benefits Commission/School Employees' Health Benefits Commission
P.O. Box 299
Trenton, NJ 08625-0299

Your request should be directed at the Secretary of the Commission, and must contain the reason you disagree with the plan's denial of your claim or coverage, and all correspondence and documents that you sent to the insurer during the plan's appeals process.[72] You may include any other information that you believe is relevant to your case. The Commission will notify you of its decision in writing and will incorporate the following language if the Commission's determination is contrary to your claim:

> If you disagree with the determination of the Commission in this mater, you may appeal by sending a written statement to the Commission within 45 days from the date of this letter informing the Commission of your disagreement and all of the reasons therefore. If no such written statement is received within the 45-day period, this determination shall be considered final.[73]

If there are no facts in dispute and your appeal rests solely on a question of law, the Commission will decide your appeal on the documents you submitted (known as the "record"); if there are facts in dispute, the Commission will send your case to an Administrative Law Judge (ALJ), who will hold a hearing subject to rules and procedures set forth in the Administrative

[70] N.J.A.C. §17:9-1.3(b)
[71] N.J.A.C. §17:9-2.14 (Policy Provisions Adoption).
[72] N.J.A.C. §17:9-1.3(a).
[73] N.J.A.C. §17:9-1.3(c)

Procedures Act.[74] A review of the Commission's practice over the past year indicates that the Commission will not hold a hearing if you are appealing a denial of service that was reaffirmed by an IRO, even if you assert that there is a factual issue in dispute; it will decide your appeal on the documents submitted. This is an area of the law, however, that has not been definitively resolved. Accordingly, if you are deciding to pursue a medical necessity denial to the Commission, please consult with an attorney.

In any event, if the Commission decides to hold a hearing, you will be given the opportunity to present your case to the ALJ. You will be responsible for any costs associated with this presentation, including fees for your attorney (if you retain one) and/or any expert witnesses you present. The ALJ will then make a recommendation about your appeal to the Commission. The Commission may accept, reject, or modify the recommendation. In any event, the Commission must make detailed findings of fact and conclusions of law that becomes a final agency decision that you can appeal in court.[75] If you still disagree with the Commission, you can appeal that decision to the Appellate Division of New Jersey State Superior Court. This appeal rests solely on the documents and evidence presented to the Commission and the ALJ below.

Federal Employees

Employees of the federal government, who reside and/or work in New Jersey, may receive health benefits through the Federal Employees Health Benefits (FEHB) Program. This program, operated by the U.S. Office of Personnel Management ("OPM"), allows government employees to choose from a range of private plans: consumer driven and high deductable plans or fee-for-service plans, either those with preferred provider organizations or health maintenance organizations, if you live (or work) within the area serviced by the plan. Pursuant to ACA, the OPM was directed to contract with private health insurers in offer federal employees the option to enroll in multi-state plans.[76] At this date, there is no multi-state plan that covers federal employees working or residing in NJ.[77]

As a federal employee, you must always follow the procedures set forth in your plan's handbook regarding "Disputed Claims" before you can bring the matter to the attention of the OPM. Timelines or different procedures for administrative appeals or appeals involving the exercise of medical judgment will be set forth in the handbook. At this time, plans do not have to provide for an external review of a disputed claim that involves denial of a claim based on medical necessity. However, if your appeal does involve such medical judgment, the OPM will employ an independent review organization (IRO) to decide your appeal.

So, the process to follow is the following: if you disagree with your plan's initial decision to deny coverage of a service or payment review, follow the directions in the "Disputed" claims section of your handbook or brochure as to how you can ask for the plan to reconsider its denial of your claim. If the plan still denies the claim and you disagree with its

[74] N.J.A.C. §17:9-1.3(d)(1)
[75] N.J.A.C. §17:9-1.3(d)(2)
[76] See §1334 of the Affordable Care Act and implementing regulations at 45 C.F.R. 800.101 et seq.
[77] http://www.opm.gov/healthcare-insurance/multi-state-plan-program/consumer/

decision, the plan's handbook and the decision itself will tell you how (*i.e.*, to whom and the time in which you must act) to write the OPM to ask them for a review of the decision.

In this way, federal employees have the right to file an external appeal with the OPM after they have exhausted appeals offered by the plan. Generally, one must file one's appeal with:

United States Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations, Healthcare
1900 E Street NW
Washington D.C. 20415-3610

With respect to all plans with which the federal government contracts, your claim will be reviewed by one of three Insurance Contract Divisions. The relevant Contract Division will generally acknowledge receipt of your appeal within 5 days, and a final decision will be rendered within 60 days.[78] With respect to multi-state plans, OPM will reach its decision within 30 days.[79] If the Contract Division needs more time or requires more information, it will contact you within 14 days of receiving your request for a review of the plan's denial.[80] You may contact the Contract Division at the number provided on the acknowledgement that you receive, but you not be able to get a decision on the phone. You will always get a written decision explaining the OPM's determination. This is a final agency decision. If you disagree with OPM's final decision, you can seek review of that determination in Federal court. The court will base its review on the information that was before the OPM, including any IRO review it conducted, when the OPM made its final decision.

Veterans Health Care and Military Programs

Veterans, and in some cases, their family members are eligible to receive their health care through the Veterans Health Administration (VHA), which is responsible for "provid[ing] a complete medical and hospital service for the medical care and treatment of veterans."[81] There are different entitlement programs through which veterans of different status and their families may receive such care, including the basic VA health care program,[82] and the Civilian Health and Medical Program of the DVA (CHAMPVA).[83] (Veterans now enrolled in the VA health care program are eligible for the Veterans' Choice program under which the VA will cover care provided by a non-VA care provider, but only for "medical needs which have been approved by

[78] www.opm.gov/healthcare-insurance/healthcare/consumer-protections/#url=Disputed-Claims.
[79] Ibid.
[80] Ibid.
[81] 38 U.S.C. §7301(b). The Veterans Health Administration ("VHA") operates an integrated system consisting of 150 medical centers, 1,400 community-based outpatient clinics, 53,000 independent licensed health care providers and other community living centers.
[82] A person eligible for VA health benefits is a person "who served in active military, naval or air service and who was discharged or released there from under conditions other than dishonorable." 38 U.S.C.§101(2) Current and former members of the Reserves or National Guard who were called to active duty by a federal order and have completed the full period for which they were called or ordered to active duty may be eligible as well.
[83] CHAMP is available to spouses and children of veterans with permanent and total service-connected disability, and some veterans who died on active duty. See also at: http://champvabenefits.com/#sthash.NmqT4oIY.dpuf.

a VA physician" where access to care at a VA facility is limited either geographically or within the time medically required for an appointment).[84] TRICARE, a health care program managed on a regional basis by the Defense Health Agency (DHA) for the U.S. Department of Defense Military Health System, is available for military personnel, military retirees, and their family members, including some members of the Reserve component of the military.[85]

The two VA programs are insurance plans under which beneficiaries are entitled to participate with no premium or enrollment fee. Nonetheless, beneficiaries of CHAMPVA, who are able to seek services from non-VA facilities and providers, are typically responsible for deductibles and co-payments, including a percentage of the amount charged. Veterans enrolled in the VA health care program, however, do not have deductibles and may only have to pay small copayments for certain procedures and prescription drugs depending on their date of discharge, service connection to condition treated, and income. Once enrolled, each veteran receives a personalized Veteran Handbook, which details his/her benefits and provides information regarding access to care.

With respect to persons enrolled in the **VA health care program**,[86] it should be noted that there are Patient Advocates located at every VA medical center. These advocates are trained professionals who can help a veteran help resolve his/her concerns about any aspect of their health care experience, especially if those concerns, such as lack of access or refusal to provide a particular service cannot be resolved at the point of care. These patient advocates may be your first line of defense. However, if you believe that you are in an emergency situation call the Veterans Crisis Line at 1-800-273-8255.

In general, persons enrolled in the VA health care benefits program have one full-year from the date of mailing of the notice of a denial of benefits, services, or coverage of a medical treatment to appeal that denial. Any decision made by the VHA on any aspect of a healthcare benefit claim may be appealed for any reason.[87] The appeals process is a multi-stage, non-linear process set in law that has evolved over decades, with a continuous open record at each stage. This means that you are allowed to submit new evidence (for example, medical records, statements etc.) at any time, and each submission of evidence requires a new cycle of review and decision-making at any time.

First, you must submit a written Notice of Disagreement (NOD) to the local HVA office/medical center that issued the decision denying your claim. The VA will respond with a Statement of the Case that entails a detailed summary of the evidence, citation to the law and regulations used by the local VA officer in making its decision, and a summary of the reasons for

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[84] Veterans Choice Program is part of the Veterans Access, Choice and Accountability Act of 2014, Pub.L. 113-146, (August 7, 2014)

[85] TRICARE is a health care program for almost 9.5million beneficiaries, including active duty service members, retired service members, National Guard and Reserve members, and their family members who are registered in the Defense Enrollment and Eligibility Reporting System (which is key to establishing eligibility for TRICARE).

[86] Once enrolled, a veteran remains in the VA healthcare system and maintains access to certain VA health benefits.

[87] Dept. of Veterans Affairs, "The Veterans Appeals Process." February 28, 2014 at 2 (VA's Appeals structure).

the decision.[88] At the same time that the SOC is mailed to you, a VA Form 9, Substantive Appeal Form, will be sent. If you are dissatisfied with any aspect of the Statement of Case, you may file a formal appeal with the Board of Veterans' Appeals by filling out the VA Form 9 and stating the benefit you want, any mistakes you find in the SOC and whether you want a hearing with a member of the Board of Veterans' Appeals that is going to hear your case.[89] You may request a hearing in Washington, D.C. where the Board is located, a videoconference hearing at your local VA office and the board member in Washington, or a hearing at your local office with a board member present. Because of scheduling delays, a videoconference hearing is the quickest way to get a hearing with a board member. These hearings are informal, though you will be required to take an oath to tell the truth. You have 60 days from receipt of the Statement of the Case, or within one year of the date that the local VHA office mailed you the initial decision, whichever is later, to file the appeal request. Hearings, however, are only scheduled after your appeal has been certified to the Board. The Board must first screen your application for review to make sure that the record is adequately developed;[90] and it can remand your request if it is not and/or reject it if you fail to allege a specific error of fact or law in the determination that you are appealing.[91] Also, if you submit new evidence prior to the hearing, the VHA must issue a Supplemental Statement of the Case.

In any case, if you have a representative, that person will be able to ask you questions at the hearing to help you explain your claim. You can add evidence to your claim at this stage, and that evidence will be reviewed by the board member hearing your case. A decision will not be made at the hearing; rather, a transcript of the hearing will be made and sent to the Board of Veterans' Appeals with your file. Unlike a traditional appeals process, the Board of Veterans' Appeals takes a fresh look at all the evidence in the record without any deference to the VHA's initial decision. This is called a *de novo* review. The Board may also secure an advisory medical opinion from one or more independent experts in addition to the expertise that is available within the department, if it believes that the medical complexity of your case so warrants.[92] If the Board does secure such an advisory opinion, you have 60 days to respond. If the opinion is not favorable, one should always respond, otherwise there is a good chance that your claim will be denied.

After reviewing the evidence in your file, the board member who heard your case will make a decision, which will be sent to you in the mail. The decision will allow, deny or remand your claim. If it is allowed or denied, the decision is considered a final agency decision. A remand will often send you claim back to the local VHA office to get further information, starting the cycle all over. If the Board of Veterans' Appeals denies your appeal, you can file a motion asking the Board to reconsider your claim. Such motions to reconsider, however, are very difficult to win and often add an additional year to the appeal. Instead of making a motion

[88] 38 U.S.C.A. §7105. You may waive review by the local regional office of your NOD to expedite the process; however, you must receive a SOC.
[89] You can also request a personal hearing with a local VA official at any time by sending a written request to your local office. At such hearings, local officials, such as a Decision Review Officer, may offer a second review of your entire file and assist you in fleshing out the basis of your appeal.
[90] 38 U.S.C. §7106(f)
[91] 38 U.S.C.A. §7105(d)(5)
[92] 38 U.S.C. §7109

to reconsider, one may also file an appeal with the U.S. Court of Appeals for Veterans Claims. You have 120 days from the date the Board of Veterans' Appeals mailed its decision to notify this court of your appeal. This court does not hold its own trials and does not consider new evidence; it reviews the decision of the Board of Veterans' Appeals. If the court decides to have oral argument on your claim, you may represent yourself or have a lawyer do so. The veteran's pro bono consortium provides free attorney representation at the Court of Appeals for veterans Clams for certain veterans. The consortium can be contacted at http://www.vetsprobono.org/.

In turn, you have the right to appeal the decision of the Court of Appeals for Veterans Claims to the U.S. Court of Appeals for the Federal Circuit. Timelines for such appeals are found in the Federal Rules of Civil Procedure.

For more information, go to www.va.gov/opa/publications/benefits_book/benefits_chap14.asp.

To receive a copy of the VA's pamphlet entitled "Understanding the Appeal Process," write to:

Mail Process Section (014)
Board of Veterans' Appeals
810 Vermont Avenue NW
Washington D.C. 20420

CHAMPVA is a heath benefits program in which the VA shares the cost of certain health care services and supplies with eligible beneficiaries (i.e., spouses and children of certain disabled veterans). You may appeal a denial of your application for CHAMPVA eligibility through the aforementioned appeals process (*i.e.*, the decision on an eligibility appeal is determined by the Board of Veterans' Appeals) though you should send your Notice of Disagreement to the Health Administration Center (HAC) in charge of administering the CHAMPVA program, now known as the Chief Business Office Purchased Care. The relevant address is:

Chief Business Office Purchased Care
CHAMPVA Appeals
PO Box 460948
Denver, Colorado 80246-0948

The procedure with respect to denials of coverage, services or payment is, however, different and closely resembles the appeal process applicable to private insurance plans.[93] If you receive an initial determination of denial (in the form of a letter denying benefits/eligibility or an Explanation of Benefits) you may request reconsideration of that denial. Your request for reconsideration (your first level of appeal) should be sent to the above address within one-year of the initial determination. If the decision involves a mental health benefits appeal, you must send your initial request for reconsideration to:

[93] This process is outlined in the CHAMPVA Guide: Helping you take an active role in your health care (October 2013); Department of Veterans Affairs, Health Administration Center, CHAMPVA, Fact Sheet 06-02 Reconsideration and Appeal Rights (July 2008).

Magellan Behavioral Health
CHAMPVA
PO Box 3567
Englewood, Colorado 80155
1-800-424-4018

In your request for reconsideration, you should identify why you believe the decision is in error and you should include new and relevant information that you previously did not submit. You should also include the EOB letter or denial letter, and you should provide all relevant facts and supporting medical documentation. You should receive a determination within 60 days from the date you appealed. If you still disagree with CHAMPVA's decision you can request a second level appeal. This appeal must be made within 90 days from the date of the reconsideration decision. In all cases, including mental health determinations, this appeal is sent to the CHAMPVA Appeals office at the address above. These second level appeal determinations are final decisions and cannot be appealed to the Board of Veterans' Appeals. You should consult an attorney to determine whether you have further remedies in court.

A request for reconsideration or appeal of a denied decision can be made by a CHAMPVA beneficiary, a health care provider who received an EOB or decision denying a claim or a representative appointed in writing by either the beneficiary or the provider. Denials that may be appealed to the HAC/Chief Business Office Purchased Care office through this process include: Benefit coverage decisions that were denied as non-covered (which are not explicitly excluded by regulation), denied coverage through the preauthorization process, denied services when bills are found to be incidental or unbundled, second level mental health reconsiderations, and claims that were not submitted on a timely basis. Eligibility appeals will be sent to the Board of Veterans' Appeals and appeals on the rating determination of a veteran's service-connected disability should be filed with your local Veteran's Administration Regional Office handling the veteran's file. CHAMPVA will not consider appeals regarding your cost-share amount, you or your family's annual deductible, the CHAMPVA Maximum Allowable Cost and denial of coverage of benefits that are specifically excluded by federal regulation.

To receive more information about the appeals process applicable to CHAMPVA beneficiaries write or call:

Chief Business Office Purchased Care
CHAPVA
PO Box 469063
Denver, Colorado 80246-9063
1-800-733-8387
http://www.va.gov/hac/contact

TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services, provides civilian health benefits for military personnel, military retirees and their dependents. The program is administered by the DHA, which in turn contracts with several large insurance companies to provide claims processing, customer service and other administrative functions. The TRICARE program offers several different health insurance plans

(such as Tricare Standard, Extra Prime, Reserve Select, Reserve Retired or for Life), and each plan is administered on a regional basis, with New Jersey, falling within the Tricare North region (managed by Health Net Federal Services, LLC).

All medical claims (except claims associated with Tricare Overseas and Tricare for Life) must be filed with your regional contractor. In most cases, claims for payment will be submitted by your provider; however, if you are traveling and receive care from a non-participating provider, you must submit your claim to your claims processor within one year of service, unless you received care oversees; under such circumstances, you have up to 3 years from the date of service. Most claims will be processed in 30 days, and you will receive an explanation of benefits detailing what was paid.

In the event that you claim is denied or a request for prior authorization, in whole or in part, you or an appropriate person may file an appeal if you believe that such determination was wrong. An appropriate person is the beneficiary, a custodial parent if the beneficiary is a minor, a person appointed in writing, by you, to represent you for the purpose of the appeal, an attorney or a non-network participating provide. A network provider may not file an appeal unless s/he is the person you have designated to represent you. If someone other than you intends to file the appeal, you must complete an Appointment of Representative and Authorization form with the appeal, otherwise it will not be processed. The appeal must be in writing and must be submitted within 90 days of the date on the EOB or denial notification letter, and in the case of New Jersey residents it must be mailed or faxed to:

Health Net Federal Services, LLC
c/o PGBA LLC/TRICARE Claims Appeals
P.O. Box 870148
Surfside Beach, SC 29587-9748
Fax: 1-888-458-2554

The issue you seek to appeal must be an "appealable" issue, and there must be an amount in dispute (though there is no minimum amount to make the denial appealable). If your denial involves a preauthorization for service, then the amount in dispute is the estimated TRICARE allowable charge for the services requested. Appealable issues do not include: eligibility for TRICARE, allowable charges such as co-pays, co-insurance or deductibles, denial of services from someone who is not an authorized provider, denial of a treatment plan when the contractor provides an alternative treatment plan, refusal of a primary care manager to refer you to a specialist, and point of service issues such as quality of care you received, except if your denial of service relates to an emergency. For non-appealable issues, you may submit a grievance. Grievances also must be in writing, and they too go to the relevant regional contractor, unless the complaint relates to dental or drug supplies in which case it goes to the contractors managing those programs. For the specific information that you should include in a grievance, go to www.tricare.mil/Resources/Appeals.aspx, and click on "grievance process."

As for issues that may be appealed, the TRICARE program separates them into Factual Appeals, Medical Necessity Appeals and Pharmacy Appeals. Each category has its own process,

though they share procedural similarities. Factual Appeals involve the denial of payment for services or supplies received or when payment is terminated for services previously authorized. Your appeal, which must be filed with the relevant contractor, must be postmarked or received within 90 days of the date on the EOB or other denial letter. You should include a copy of the EOB and supporting documentation. If the payment you are appealing is less than $50.00 the contractor's reconsideration of the denial is final. If the amount is more than $50.00, you may appeal the decision to the DHA. This appeal must be postmarked or received within 60 days of the date of the first appeal decision. You should include a copy of the decision with all supporting documents. If the disputed amount is less than $300.00, the DHA's decision is final. If the payment is more than $300.00, you can request an independent hearing. This request for a hearing should be sent to the DHA, and must be postmarked or received within 60 days of the date of the appeal decision. You should include a copy of the DHA decision being appealed and any supporting documents not previously submitted. A hearing will be held at a time that is convenient to you and the government; and the hearing officer will render a recommendation to the DHA director. The DHA director or the Asst. Secretary of Defense for Health Affairs will issue a final decision that may be reviewed by a court if you are still dissatisfied.

Medical Necessity Appeals involve the denial of a prior authorization for requested services or supplies. Such appeals may be expedited, if the denial involves previously approved inpatient stays or ongoing treatment. The decision will explain how to file such expedited appeal. Standard medical necessity appeals, like factual appeals, must be postmarked or received within 90 days of the date on the EOB or denial letter, and must include a copy of that denial. Again, the relevant contractor will review your case and issue a reconsideration decision. If you disagree with that decision you may appeal it to the national quality monitoring contractor (whose address will be included in the decision). This request must also be postmarked or received within 90 days of the date on the reconsideration decision. This decision is final unless you are disputing a service that is valued at $300.00 or more. In such instances, you can request the DHA to schedule an independent hearing. From here, the process is the same as it is for factual appeals.

Pharmacy Appeals involve a denial of your pharmacy benefit, including a payment on a claim, a request for prior authorization or a claim that the drug prescribed is medically required. The appeal must be in writing and signed, and should include a copy of the claim decision and the reason why you disagree with the decision. It must be postmarked or received by Express Scripts within 90 calendar days from the date of the decision at:

Express Scripts, Inc.
P.O. Box 60903
Phoenix, AZ 85082-0903

Check the decision you receive to determine whether it is final, or whether you are able to have it reviewed by the DHA.

CONCLUSION

It is true that appealing an insurance denial can be overwhelming and unpredictable. By their nature, insurance appeals are fact-specific. They concern your medical history and current condition, the particulars of your insurance plan, and the specific types of medical service that your doctor recommended. But it is also true that you will never secure the benefits you believe you deserve unless you try. On pp. 47-50 (Contacts), we list specific agencies that can assist you in preparing your appeal given the type of insurance plan you have.

GLOSSARY

Administrative Denial is a refusal to pay a claim or authorize a service or supply based on provisions or limitations in one's contract or other grounds not involving the exercise of medical judgment.

Authorization means a determination by your health benefits plan that based on the information provided, the health service, procedure or supply, which you or your physician requested be provided to you, is medically necessary.

Adverse Benefit Determination means a decision by your insurance company to deny, reduce, terminate or fail to make payment (in whole or part) for a benefit resulting from the application of any utilization review, contract exclusion or any other ground that does not involve the exercise of medical judgment, such as termination of your health insurance coverage.

Appeal is a request for your health insurer or plan to review an adverse benefit decision or denial of coverage or payment.

Authorized Representative is someone who you choose to act on your behalf with your health insurance plan such as a physician, family member or other trusted person.

Balanced Billing is when a provider bills you for the difference between the provider's charge and the amount your insurance company is willing to pay pursuant to the terms of your plan.

Claim means your request or the request of your health care provider for payment relating to the care or supplies that you were given and which are covered under your health insurance plan. Your **Claim File** consists of all information and documentation that you or your provider submitted, typically including itemized receipts and a claim form, as well as any information and documentation that was considered in your insurer's review of your request for treatment, service, or supply. The file must be provided to you by your insurance carrier free of cost upon request.

Co-Insurance is a percentage of the cost of your covered health care costs that you are required to pay under your health insurance plan after you have met your annual deductible.

Co-Payment is a flat fee, or set amount you have to pay for a specific health related service. Co-payments are very common in managed care plans and in drug plans such as Medicare Part D.

Cost-sharing is the share of the total medical costs, which are covered by your insurance plan that you must pay out of your own pocket. This term includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums one may be required to pay.

Covered person means a person on whose behalf an insurance carrier offering the health insurance plan is obligated to pay benefits or provide services pursuant to the terms of the plan.

Covered service means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

Deductible: the total amount you must pay for medical treatment before your health plan will start covering the cost of your medical care for you and/or your dependents.

Denial: a decision by an insurance company not to pay for treatment either before it is delivered or after you have already received it. In New Jersey, denials are categorized as either administrative denials or Utilization Management (UM) denials.

Eligibility Assessment is a determination as to whether a person has the right to enroll and receive coverage under a particular type of insurance coverage, such as Medicaid or Medicare, or a particular private health insurance plan.

ERISA means the Employee Retirement Income Security Act of 1974 (ERISA), (Pub. L. 93-406, 88 Stat. 829, enacted September 2, 1974, codified in part at 29 U.S.C. §18) is a federal law that establishes minimum standards for pension plans in private industry and provides for extensive rules associated with employee benefit plans, including health benefit plans.

Excluded Services are health care services or supplies that your insurance plan does not pay for or cover.

Explanation of Benefits (EOB) is the form or document that is sent to you by your insurance company after it has processing your claim for services requested or provided. It must include the treatment requested or provided (including the code employed), the date of service if already rendered, whether the service is covered in whole or part, and what you, the patient, should pay (for example, if a co-payment, co-insurance, or deductible applies).

External Appeal or External Review is a review of your plan's decision to deny coverage for or payment of a service by an independent third-party not related to the plan. Typically, if your plan denies your internal appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process isn't yet completed. External review is available when the plan denies treatment based on medical necessity, appropriateness of provider or treatment, health care setting, level of care, or effectiveness of a covered benefit, or when the plan determines that the care is experimental and/or investigational. Each of these matters involves exercise of medical judgment. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The plan must accept this decision.

Fully-Insured Plan is a health plan purchased by an employer from an insurance company where the insurance carrier bears the financial responsibility for paying out the cost of your health benefits under the terms of the plan.

Grandfathered Plan is a health plan that was in effect on March 23, 2010 and is not governed by the appeal provisions set forth in the Patient Protection and Affordable Care Act. However,

to the extent these plans were regulated by New Jersey law, the appeals process outlined herein applies.

Grievance is a complaint that you communicate to your health insurer or plan about the quality of services you received or any matter relating to your health insurance plan; except that it does not include complaints about adverse benefit determinations; that is, either administrative or UM denials.

Health Benefits Plan means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in New Jersey.

Independent Utilization Review Organization (IURO) is an independent organization, comprised of physicians and other health care professionals representative of active practitioners in New Jersey, with which the Department of Banking and Insurance contracts to conduct independent medical necessity or appropriateness of services appeal reviews brought by the member or provider on behalf of the member, with the member's consent.

Internal Appeal is the first step one must take to challenge an adverse benefit determination and it involves filing a written complaint to the insurance company requesting reversal of its decision. Denials based on medical necessity and appropriateness of care, including denial of a request to receive care from an out-of-network provider, are subject to a formal internal appeal process regulated by the State. Persons covered by individual and group plans are entitled to a Stage 1 appeal which is directed to the insurance company's medical director or the physician who rendered the denial; members of group plans, typically through an employer, are also entitled to a Stage 2 appeal which is heard by a panel of physicians or other healthcare professionals selected by the carrier.

Medically Necessary Health Care Services or supplies are those services that a health care provider, exercising his prudent clinical judgment, would provide to you for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Such services are provided in accordance with generally accepted standards of medical practice, and are considered clinically appropriate in terms of type, frequency, extent, site and duration.

Medical Necessity refers to a decision by your health plan that your treatment, test, or procedure is necessary for your health or to treat a diagnosed medical problem. Most health plans will not pay for healthcare services that they deem not "medically necessary" pursuant to medical utilization standards that they employ.

MEWA (Multiple Employer Welfare Arrangement) means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan) which is established or maintained for the purpose of offering or providing welfare benefits, such as medical, surgical, hospital care or other health benefits, to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or arrangement that is established or maintained pursuant to one or more collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association.

Out-of-Network or Non-Preferred Provider is a medical provider (such as a doctor or treatment center) which does not have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-preferred provider. How much more depends on what your health plan specifically states.

Out-of-Pocket Maximum is the largest amount you will pay toward the cost of health care each year. After you have paid enough in deductibles, co-payments and co-insurance to reach the out-of-pocket maximum, the insurance company pays the rest of your health care costs for the year

Network, Preferred or Participating Provider is a provider which, under contract with your HMO or managed health benefit plan, has agreed to provide services to you with an expectation of receiving payment, other than a copayment or deductible, directly or indirectly from your plan.

Patient Protection and Affordable Care Act (ACA): the national health care reform law signed by President Obama in 2010.

Prior Authorization is a requirement that your physician or other health provider obtain approval from your health plan to prescribe a specific treatment or medication for you. Without this prior approval, your health plan may not provide coverage or payment for such treatment or medication

Rider: a condition or additional provision that is added to an insurance policy that changes the benefits provided.

Rescission of health insurance benefits involves the retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Self-Insured Plan is a type of plan where the employer collects premiums from enrollees and assumes the responsibility for paying employees' and their dependents' medical claims. A self-insured plan is usually offered by a large employer or union. These employers or unions may contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator (typically a health insurance company), or they can be self-administered.

Substantiating Documentation means any information specific to the particular health care service provided to you; documentation prepared by either you or your provider.

Urgent Care means a non-life threatening condition that requires care by a provider within 24 hours.

Urgent Care Claim is a claim for medical care or treatment with respect to which application of the time periods for making standard determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or that, in the opinion of a physician with knowledge of the claimant's medical condition , would subject that person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent or Emergency Appeal is an expedited process that you may request when the underlying claim that is denied involves emergency care or continuity of care (when you have received emergency services but have not been discharged from a facility) and withholding medical care places your life or health in jeopardy.

Utilization Management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines in order to recommend or determine whether a health care service given or proposed to be given to a member should or will be reimbursed, covered or otherwise provided under the plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization or ambulatory procedures and retrospective review.

Utilization Management (UM) Denial is a refusal to pay a claim or authorize a service or supply because the insurance company has determined that the service or supply is not medically necessary, the provider is inappropriate or the treatment is experimental or investigational, cosmetic, or dental rather than medical. UM denials involve the insurance company's exercise of medical judgment, including the situation where the plan denies your request to see an out-of-network provider because you assert that the plan's network does not have any providers who are qualified, accessible and available to provide the medically necessary service.

ADDITIONAL DOCUMENTS

Sample Claim File Request Letter

PLEASE NOTE: THIS IS NOT AN APPEAL
Sent by Certified Mail
Return Receipt Requested

Date:

[Insurance Company Name]
[Address or Fax Number]
Patient Name:
Covered Person/Member Name:
Member ID#:
Description of Service Denied:
Date of Denial:
Provider's Name:

To Whom It May Concern:

I am writing to request a copy of all standards, policies, criteria, and/or any other documents involved in your company's decision to issue the denial of benefits or payment referenced above.

I have enclosed a copy of the Explanation of Benefits/denial letter that I received.

Please send the requested documents to me at [insert your complete mailing address].

If you have any questions about this request, please call me at [insert your phone number].

Sincerely,
[Your name]

Enclosure

Sample UM Appeal Letter

[Your Name]
[Address]
[Phone Number]

[Date]
[Insurer Name/Address]
Patient Name:
Member Name (if different):
Member ID#:
Group (if insured through an employer or group):
Plan:
Provider's name and identification number:
Treatment (including code):
Treatment Date:
Denial Date:

To Whom It May Concern:

I am appealing the denial of [name of treatment] dated [date of denial] for service provided/requested on [date of service or authorization submission].

Based on the Explanation of Benefits that I received, I understand that the insurance company has denied coverage or payment for this treatment because [include the exact language from the denial]. I have included a copy of the denial that I received.

I believe the denial should be overturned for the following reasons [list each of the reasons showing that the treatment is covered by your plan and that the treatment, supply or prescription satisfies the medically necessary criteria employed by the insurer, including your medical needs, prior unsuccessful treatments, and the expected result].

I have included the following medical records [list the copies of documents you are including].

I have enclosed a letter of support from my doctor that states [summarize the information in the doctor's letter, which explains why your health care provider believes that this treatment is clinically appropriate]. I have also included a personal statement [briefly summarize the information in your personal statement that explains how you have been impacted by the insurer's denial].

For the reasons outlined above, I request that the denial be reversed. Please do not hesitate to call me if you require additional information or have any questions.

Sincerely,
[Your name]
Enclosures

Sample Administrative Appeal Letter

[Your Name]
[Address]
[Phone Number]
[Date]
[Insurer Name/Address]
Patient Name:
Member Name (if different):
Member ID#:
Group (if insured through an employer or group):
Plan:
Provider's name and identification number:
Treatment (including code):
Treatment Date:
Denial Date:

To Whom It May Concern:

I am appealing the denial of [name of treatment] dated [date of denial] for service provided/requested on [date of service or authorization submission].

Based on the Explanation of Benefits that I received, I understand that the insurance company has denied coverage or payment for this treatment because [include the exact language from the denial]. I have included a copy of the denial that I received.

I believe the denial should be overturned for the following reasons [list each of the reasons showing that plan exclusion or contract limitation was incorrectly or inappropriately applied, that deductible or copayments were erroneously calculated, or any reason appropriate to the nature of your dispute with the insurer's interpretation of the plan].

I have included the following records in support of my position that the service I requested or received should be authorized or paid [list the copies of documents you are including].

[If relevant] I have enclosed a letter of support from my provider that states [summarize the information in the doctor's letter, which explains why your health care provider believes that this treatment is clinically appropriate]. I have also included a personal statement [briefly summarize the information in your personal statement that explains how you have been impacted by the insurer's denial].

For the reasons outlined above, I request that the denial be reversed. Please do not hesitate to call me if you require additional information or have any questions.

Sincerely,
[Your name]
Enclosures

Sample Representative Authorization Letter

[Insurer Name/Address]

To Whom It May Concern:

I, [your name], freely and willingly consent to allow [name of authorized individual, medical, or legal entity], to obtain and review my medical records and discuss my health information concerning [describe the denial] with [name of the insurer].

I also consent to allow [name of authorized individual, medical, or legal entity] to represent me in this dispute with [name of insurer] concerning my appeal.

I understand that I may revoke this consent at any time and will provide written notice to do so.

_____
Signature

_____
Address

_____
Phone Number

_____
Subscriber ID#

_____
Date

Personal Statement

Some people feel that they are profoundly affected by their insurance plan's denial of treatment. If this is the case for you, consider whether you would like to express that adverse impact in writing. If so, it is best to summarize your feelings in a separate document, so you can keep your appeal letter as fact-specific as possible. Here are some questions you should address in a personal statement, if you choose to write one:

- How long have you had this medical condition?
- What does this medical condition mean for you?
- How has your personal life been altered by this denial?
- How has your work life been affected?
- Are there other effects that you have noticed?
- What are the short and long term effects of this denial?
- What other treatments have you tried unsuccessfully?
- What were you told by your doctor concerning this treatment?

A personal statement is not required when filing an appeal, although it may have some influence on a decision maker, and may help them understand your situation better.

SUGGESTIONS FOR PROVIDERS:
WRITING THE APPEAL OR A LETTER OF SUPPORT

(This information offers suggestions to you, as a provider, if your patient's health insurance company has denied the medical service or treatment you recommended and believe is medically necessary for his/her treatment, and the patient has asked you for assistance).

As a provider, you may submit **an appeal of a denial** on your patient's behalf, with the patient's consent. When doing so, it is important to provide documentation that supports how the treatment you recommended addresses the patient's specific medical needs. Please note that often the provider is in the best position to articulate to the insurer why the service, treatment or prescription is clinically appropriate and should be covered. Before drafting your patient's appeal, you should review the insurance company's denial to understand why coverage for this service was denied. If you do not understand the basis for the denial, call the insurance company to get more information and request the criteria/medical utilization standards that were used. If you would prefer that the patient get this information, please let her know as soon as possible. Appeals are time sensitive. Second, you should review the medical records your office has to ensure there is supporting information and documentation for the treatment you are recommending.

In the letter appealing the insurance company's decision to deny coverage or payment, be sure to:

- Include the date and reason for the original denial and include a copy of the original denial notice (EOB) with your appeal;
- State your expertise in recommending and/or providing this treatment (*e.g.*, your particular training, education, or specialized experience);
- Describe the patient's unique circumstance (*e.g.*, when first diagnosed, other unsuccessful treatments, how this condition is unique);
- Describe how your patient's medical condition specifically meets the criteria used by the insurer using as much detail as possible;
- If you believe that the insurer's utilization criteria are not clinically appropriate, refer to generally accepted medical practices that you believe are more appropriate;
- Refer as much as you can to the patient's medical record, preferably with specific cites to particular medical visits and diagnostic results;
- Explain unsuccessful treatments and how and why this service is expected to improve the patient's condition;
- Detail why this service is the most appropriate and cost-effective for this patient;
- Provide any peer-reviewed medical literature that supports this service if it is unique or considered experimental or unproven; and
- Include a copy of all medical records or other documents you reference.

It is best to retain a copy of the appeal letter and all of the medical records that are included. Send a complete copy to the patient as well. If this appeal is denied again, the patient may be entitled to another internal or external appeal. In order for the patient to effectively pursue his claim, he will need a copy of everything that you submitted on his behalf.

Appealing a denial by a health insurance company may be a time consuming process. However, please understand that you and your staff play a very important role in this process, and some patient's may not be able to undertake the process themselves. In such instances, you have the opportunity to make a huge difference in the outcome of a patient's appeal.

If you are unable to submit the appeal on the patient's behalf, you still can help by writing **a letter of support** that the patient herself should enclose with their appeal letter.

Please keep in mind that a patient has limited opportunities to appeal a denial issued by an insurance carrier. A provider's letter of support can mean the difference between whether an appeal is successful or not. In general, when drafting a letter of support, you should include as much detail as possible concerning the patient's particular medical needs, how the insurance plan's criteria are met, and copies of all medical records that support your statements. If you do not have sufficient information or knowledge to draft such a letter, you should tell the patient so she can locate another provider to assist with the appeal.

Here are some suggestions to keep in mind before you begin drafting the letter of support:

- Review the denial. If you do not understand the criteria or utilization standards being applied, ask the insurance company to send you a full copy of its coverage guidelines.
- Review the patient's medical history to make sure you can support the position that the patient's medical needs meet the insurance plan's criteria, unless you believe that the criteria are clinically inappropriate and do not satisfy generally accepted medical practice. In such cases, provide support for your belief that the treatment is medically necessary.
- Identify those test results, pictures, and/or medical records that support the requested treatment. Make copies of them to provide to the carrier.
- If the treatment is considered experimental, investigational, or unproven, gather the citations for studies, medical journals, and articles that support the treatment as medically necessary.

Drafting the letter:

- Identify yourself and provide background information (*e.g.*, how long you have known the patient, why the patient came to you and your particular expertise that qualifies you to make this recommendation).
- Provide the insurance plan's criteria and reason for the denial.
- Articulate the reasons the denial should be overturned, including any information in the medical records that supports those reasons. Remember to link the patient's medical needs as closely as possible to the criteria that are being applied and address each criterion individually with supporting documents.
- Describe how other treatments have been unsuccessful, using references to medical records, if applicable.
- Provide a clear explanation for why this is the most appropriate and cost-effective treatment given the patient's medical condition.
- Describe the expected positive effects of this treatment for your patient.

The content of a letter of support does not substantially differ from the content of the denial itself if written by the provider. You, the provider, just have less administrative responsibility in processing the appeal. When writing a letter of support, the patient is the one communicating with the insurance company.

CONTACT LIST

For questions regarding to small group and individual plan appeals contact:

New Jersey Appleseed Public Interest Law Center
50 Park Place, Rm. 1025
Newark, NJ 07102
Phone: 1-973-735-0523
Fax: 1-973-735-0602
Web: www.njsentinelproject.org
Email: contact@njsentinelproject.org

New Jersey Citizen Action
744 Broad Street, Rm. 2080
Newark, New Jersey 07102
Phone: 1-973-643-8800
Fax: 1-973-643-8100

New Jersey Department of Banking and Insurance
Consumer Inquiry and Response Center
P.O. Box 471
Trenton, NJ 08625-0471
Phone: 1-609-292-7272 (general), 1-800-446-7467 (automated hotline)
Fax: 1-609-454-8468
Web: www.state.nj.us/dobi/consumer.htm

For questions regarding Medicaid/NJ Family Care appeals contact:

Community Health Law Project
185 Valley Street
South Orange, NJ 07079
Phone: 1-973-275-1175
Fax: 1-973-275-5210
Web: www.chlp.org
Email: chlpinfo@chlp.org
Additional Offices: Bloomfield, Carneys Point, Collingswood, Eatontown, Elizabeth, Hackensack, Jersey City, Mount Holly, Northfield, Toms River, and Trenton.

Legal Services of New Jersey
P.O. Box 1357
Edison, NJ 08818-1357
Phone: 1-888-576-5529
Web: www.lsnj.org

NJ FamilyCare
Phone: 1-800-701-0710
Web: www.njfamilycare.org

New Jersey Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712
Phone: 1-800-356-1561
Web: www.state.nj.us/humanservices/dmahs/home

For questions regarding Medicare, Medicare Health Plans, Medicare Prescription Drug appeals contact:

New Jersey State Senior Health Insurance Information Program (SHIP)
Department of Health and Senior Services
Division of Aging and Community Services
369 South Warren Street
Trenton, NJ 08608-2308
Mailing Address:
P.O. Box 360
Trenton, NJ 08625-0360
Phone: 1-800-792-8820
Web: www.state.nj.us/health/senior/ship.shtml

Medicare Rights Center
520 Eighth Avenue
North Wing, 3rd Floor
New York, NY 10018
Phone: 1-212-869-3850
Fax: 1-212-869-3532
Web: www.medicarerights.org

For questions about self-funded plan appeals (typically, plans provided by large employers) contact:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, DC 20210
Phone: 1-866-444-3272
Web: www.dol.gov/ebsa

For questions about government employee health plan appeals contact:

State Health Benefits Commission/School Employees' Health Benefits Commission50 West State Street
P.O. Box 295
Trenton, NJ 08625-0295
Phone: 1-609-292-7524
Web: www.state.nj.us/treasury/pensions/contract.shtml

Office of Personal Management
Employee Services
1900 E Street, NW
Washington, DC 20415-1000
Web: www.opm.gov/about-us/contact-us/
Phone: Employee Services: 1-202-606-7400
Federal Health Insurance: 1-202-606-1234
Dental, Vision, Life and Long Term Care Insurance: 1-202-606-143
Multi-State-Plan Program: 1-202-606-2128

For questions about veteran health plan appeals contact:

U.S. Department of Veterans Affairs
Veterans Health Administration
810 Vermont Avenue, NW
Washington, DC 20420
Phone: 1-877-22-8387 (Health Care Benefits)
Web: www.va.gov/health

Newark VA Regional Office
20 Washington Place
Newark, NJ 07102-3174
Phone: 1-800-827-1000
Web: www.vba.va.gov/ro/east/newrk/

For questions about which appropriate agency you should contact to understand your rights to appeal with respect to the type of health plan coverage you have, or questions or complaints you have about a health insurance plan that is regulated by the State contact

New Jersey Department of Banking and Insurance
Consumer Inquiry and Response Center
P.O. Box 471
Trenton, NJ 08625-0471
Phone: 1-609-292-7272 (general), 1-800-446-7467 (automated hotline)
Fax: 1-609-454-8468
Web: www.state.nj.us/dobi/consumer.htm

For questions about the Patient Protection and Affordable Care Act, go to:

New Jersey for Healthcare Coalition
Web: www.njforhealthcare.org

Health Insurance Marketplace
Web: www.healthcare.gov (general information)
www.healthcare.gov/how-do-i-appeal-a-health-insurance-companys-decision (appeals)