ORDER NO: A17-103

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE ESTABLISMENT OF UNIFORM PRE-SERVICE AND POST-SERVICE INTERNAL APPEAL FORMS	)))	ORDER

This matter having been opened by the Commissioner of the Department of Banking and Insurance ("Commissioner") pursuant to the authority granted in N.J.S.A. 17:1-15, 17:1-15e, N.J.A.C. 11:3-4.7(d) and 11:3-4.7B, and all powers expressed or implied therein;

IT APPEARING that pursuant to N.J.S.A. 39:6A-3.1, 39:6A-4 and N.J.A.C. 11:3-4.7(c)5, insurers must file Decision Point Review Plans with the Department that include, "an internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or administration of a test;" and

IT FURTHER APPEARING that N.J.A.C. 11:3-4.7B sets forth the standards that all insurer internal appeal procedures must follow; and

IT FURTHER APPEARING that N.J.A.C. 11:3-4.7B(c) states that all internal appeals shall be initiated using forms established by the Department; and

IT FURTHER APPEARING that forms developed by the Department have been distributed to representatives of the provider and insurer community for comment, and the Department has considered those comments; and

IT FURTHER APPEARING that pursuant to N.J.A.C. 11:3-4.7(d), the Commissioner may, by Order, mandate the use of uniform forms by insurers and providers;

THEREFORE IT IS on this 8th day of February, 2017 ORDERED that:

1. Effective April 17, 2017, the New Jersey PIP Pre-Service Appeal Form and the New Jersey PIP Post-Service Appeal Form, attached as Appendix A and B to this Order, shall be used by all providers to submit requests for internal appeals. Additional information and guidance on use of the forms shall be provided in a Frequently Asked Questions document available on the Department's website.

Richard M. Badolato
Commissioner

Appendix A

NEW JERSEY PIP PRE-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	**11. CITY**	**12. STATE**	**13. ZIP**

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME
17. SPECIALTY	**18. TAX ID #**	**19. NPI #**
20. ADDRESS (No. Street)	**21. CITY**	**22. STATE** / **23. ZIP**
24. TELEPHONE # (Include Area Code)	**25. FAX # (Include Area Code)**	**26. EMAIL ADDRESS**

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ *ORIGINAL APTP FORM
- ☐ *APTP DECISION/RESPONSE DOCUMENT
- ☐ *APPEAL RATIONALE NARRATIVE
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ DIAGNOSTIC REPORT(S)
- ☐ PEER REVIEW REPORT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe):

PRE-SERVICE APPEAL ISSUES

30. DATE(S) OF REQUEST FROM → TO						31. CPT, HCPCS, NDC	32. RESPONSE NOT RECEIVED WITHIN 3 BUSINESS DAYS YES INDICATE WITH X	33. ADMINISTRATIVE DISPUTE YES INDICATE WITH X	34. MEDICAL NECESSITY DISPUTE YES INDICATE WITH X
MM	DD	YY	MM	DD	YY				

* Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

35. SIGNATURE OF PROVIDER _____ 36. DATE _____

Appendix B

NEW JERSEY PIP POST-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	**11. CITY**	**12. STATE**	**13. ZIP**

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME	
17. SPECIALTY	**18. TAX ID #**	**19. NPI #**	
20. ADDRESS (No. Street)	**21. CITY**	**22. STATE**	**23. ZIP**

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ *ORIGINAL BILL (HCFA/UB)
- ☐ APTP DECISION/RESPONSE
- ☐ AUDIT REPORT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe):
- ☐ *EXPLANATION OF BENEFIT/PAYMENT
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ NETWORK TERMINATION DOCUMENT
- ☐ *APPEAL RATIONALE NARRATIVE
- ☐ PEER REVIEW REPORT
- ☐ PPO CONTRACT

POST-SERVICE APPEAL ISSUES

30. EOB ID	31. TOTAL BILL REIMBURSEMENT	32. EXPECTED BILL REIMBURSEMENT	33. **BILL LEVEL APPEAL CODE(S) 1-10

34. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S

* Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only

** Indicates sections that should be completed using the letter(s)/number(s) that correspond to the reason codes on the back of this form

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39. SIGNATURE OF PROVIDER _____ 40. DATE _____

NEW JERSEY PIP POST-SERVICE APPEAL
REASON CODES

	BILL LEVEL APPEAL CODES
1	Improper Deductible Applied
2	Improper Co-pay Applied
3	Improper Interest Applied
4	Interest Due - Payment Not Made Timely
5	Bill Processed Under Wrong Patient
6	No Response To Bill Submitted Post 60 Days
7	Improper Application of Coordination of Benefits
8	Improper Use of PPO - Not Participating In Network
9	Improper Use of PPO - Terminated From Network
10	Improper Denial Based on Coverage Investigation

	LINE LEVEL APPEAL CODES
A	Improper Application of Fee Schedule Amount
B	Improper Application of Modifier Reduction
C	Improper Application of Multiple Reduction Calculation
D	Improper Application of Daily Max Cap Calculation
E	Improper use of National Correct Coding (NCCI)
F	Improper Application of U&C Amount
G	Improper Application of PPO Amount
H	Improper Application of Pre-cert Penalty Co-pay
I	Improper Application of Voluntary Network Penalty Co-pay
J	Improper Application of Prospective Medical Necessity Denial
K	Improper Application of Retrospective Medical Necessity Denial
L	Improper Application of Bill Audit Reduction
M	Improper Application of Medical Code Review Reduction
N	Improper Application of Peer Review Reduction
O	Improper Application of IME Reduction
P	Improper Application of Missing Supportive Medical Records Denial
Q	Improper Application of Coordination of Benefits
R	Data Capture Error Caused Improper Reimbursement
S	No Response to Services Billed