NJAC 11:3-4.7B Requirement for insurer Internal Appeals procedure

(a) The internal appeal procedure in an insurer's Decision Point Review Plan (DRP Plan) shall meet the requirements in this section.

(b) Insurers shall only require a one-level appeal procedure for each appealed issue before making a request for alternate dispute resolution in accordance with NJA 11:3-5. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to making a request for alternate dispute resolution. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider for the same service.

(c) All appeal shall be initiated using the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d) and posted on the Department's website.

(d) The appeal forms and any supporting documentation shall be submitted by the provider to the address and/or fax number designated for appeals in the insurer's DPR Plan. Pursuant to N.J.A.C. 11:1-47, insurers may permit electronic filing of appeals by providing the process for electronic filing in its DPR Plan.

(e) There shall be two types of internal appeals:

1. Pre-Service: Appeals of decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively know as "services"); and
2. Post-Service:Appeals subsequent to the performance or issuance of the services.

(f) A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

(g) A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

(h) Decision on pre-service appeals shall be issued by the insured to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation.

(i) Decisions on post-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation.

(j) Nothing in this section shall be constructed so as to require reimbursement of services that are not medically necessary or to prevent the application of penalty co-payments in N.J.A.C. 11:3-4.4(e), (f) and (g).