PIP FOR ATTORNEYS: A NEW VIEW

The New Insurer Internal Appeals Procedures - What You'll Be Seeing

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The new PIP standard appeal forms will be required for use as of April 17, 2017. Allegedly proposed to simplify things, they are onerous, confusing and cumbersome. Failure to properly complete the forms will result in claims being barred. In many cases, simple errors will deprive claimants of their rights to arbitrate and to present their cases properly to arbitration. The same regulation imposes no penalties on insurers for simply ignoring these appeals. A provision that caused a penalty included in the proposal was deleted from the adoption. That's your "new view" of part of the process that was originally enacted to expeditiously get patients' their medical bills paid.

The question first arises why attorneys, who do not do PIP arbitrations, should care. The answer is simple; less and less providers will be willing to treat pip patients:

1. Many a provider that does not regularly do PIP cases has contacted the undersigned even before the newest round of requirements were enacted, asking how to deal with the paperwork required. After I have explained, in the simplest fashion possible, what they need to do, many have simply responded "So you are telling me it is not worth doing!" Clearly the more onerous the paperwork, the more likely many providers will stop taking PIP patients. This is not merely anecdotal. I have had many clients stop treating PIP patients simply because of the extreme hassle of getting paid on PIP claims.
2. Providers willing to take on PIP
3. patients have always been limited. Often these patients are unable to make any payments as they go, thus providers must wait. Added cost and expense of processing paperwork coupled will minor errors meaning a loss of the ability to get paid clearly make it less advantageous and will make more doctors unwilling to take these cases on.

We are all left with dealing with these amendments and forms, despite many in this area as well as the NJAJ's attempts to suggest alternatives that were more workable. The Commissioner did make a change or two to the original forms, I should admit. Originally the forms failed to include "Coverage" as a basis for a post service appeal at the bill level. At the line item level, they added prospective denials, retrospective denials, bill audit and medical code reductions.

Many patients' attorneys do not believe that dealing with PIP issues is their problem and it is something I do not understand. Maximizing a patient's PIP reimbursement minimizes their lien

claims. Cooperating with a patient's providers maximizes goodwill and cooperation. The reasons are endless, but most importantly, you, the patient's attorney are in a unique position to resolve issues early and make sure the providers are aware of same. In fact, doing so, will help your own business bottom line as endless calls and requests for documents will cease. Many of you are probably unaware of the numerous calls and requests your staffs are fielding looking for the same information.

What trial attorneys should do in light of the new requirements:

1. Immediately upon intake of a client, contact all of their treating doctors and make sure they are aware of the new forms. Many will not be. These type of things do not hit the newspapers!
2. Make sure the providers you regularly deal with have an attorney that regularly deals with PIP arbitrations. Understand that only those that are regularly in the trenches get to really understand how the arbitrators will ultimately rule on issues that arise and have the past experience to avert problems. Many PIP attorneys will also take the time to educate the providers.
3. Advise the providers that you regularly deal with to immediately advise you of any problems. This is crucial. The Commissioner in the Frequently Asked Questions regarding The Implementation of The Appeal Rule (http://www.nj.gov/dobi/pipinfo/internalappealrulechanges.html) has stated:

> Q: Can either party in an arbitration submit additional documentation at the arbitration that was available but not included as part of the internal appeal?
>
> **A:** The Department addressed this issue in its response to comments on the rule: "The Department believes, and has stated, that the internal appeal process is the venue where the issue being appealed by the provider should be addressed fully. Although there is no specific provision for it in the rule, at arbitration, both parties can object to additional documentation and information being produced that was available at the time of the internal appeal but not submitted. The Dispute Resolution Professional should specifically address whether such documentation or information should be considered in his or her decision." The Dispute Resolution Professional's determination in this matter should be made in accordance with the existing No-Fault Arbitration Rules.

   This section is especially troublesome when it comes to coverage issues. We all know how it goes. A precertification request or an EOB might simply state that the case is "under investigation". No reason, no explanation. Efforts to find out what the problem is are ignored or the insurer claims they are not at liberty to reveal what the problem is.

   It is crucial that you, the patients' attorneys, are immediately aware of the problem.

4. Take real action, as soon as possible, to establish eligibility and address any concerns – and do it in writing, copying your clients' providers.

Too often, I see PIP claims where early on providers are advised of an investigation or delay in coverage and nothing is done until the file is given to me to arbitrate, often a year or more

later. The patient is no longer seeing his treating physician and needed paperwork – such as a telephone bill around the date of loss – no longer exists.

So let's start at the very beginning. Keep in mind, while you might not to have to pay a provider's lien claim if a large lien (other than co-pay and deductible) is due to the provider's fault, your patient will have to pay the lien when it is the patient's or your fault. This is often the case when the patient fails to cooperate or fails to attend IMEs and benefits are denied for this reason.

Furthermore, the provider may be barred by providing proofs at the time of arbitration if they were not included in an appeal. So what should you do?

Day One: Have the client bring in, tell you about or fill out the following:

1. The police report.
2. The PIP application.
3. Proof of Residency – current phone bills, leases, bank statements, employment statements, unemployment statements – anything that proves their address. Get a driver's license, but realize that since people rarely update properly their licenses, insurers rarely accept them.
4. All medical providers they have seen.
5. If they were in a prior accident, the details including medical providers seen as to that accident.

Day One to Day Two and Beyond: Immediately recognize potential problem cases and get the proofs:

1. **Children of divorced parents** – Try to get school enrollment records.
2. **People who have no proof of where they live** -Try to get the landlord or the actual lessee or owner to sign a certification.
3. **People who state they are married but are really not** - Do not simply accept someone who states they are married as really being married – ask them if they are legally married. Common law marriage does not confer PIP benefits.
4. **People who might be just visitors** – You can live with your sister for 6 months, but if your intent is to go back to your home country you are not a resident entitled to benefits.
5. **People with out of state insurance policies** – Be very careful here. Laws require updating insurance so if the client has lived in NJ too long there will be problems getting coverage. An out of state policy might be subject to the deemer law conferring NJ benefits. Also be wary of insurers trying to get the client to select another state's law, such as NY, when NJ would apply, possibly conferring greater benefits.
6. **Accusations of resident relatives with coverage when the patient is going after a host policy** – Truly question the client about the resident relatives in the home who might have converage. Cousins and a wife of a cousin are relatives under the regulations. A step-dad might be. Get a properly executed Affidavit of No Insurance.

7. **Healthcare primary policies -** You need to understand the rules and get the proper information. Brothers and sisters are never covered under one another's policies, yet the law applies to the insured and any relative in his household. In such a case, immediately provide the PIP carrier with a letter that the individual is not covered under the health insurer and demand PIP coverage.
8. **People with owned but uninsured vehicles** – Make sure you get information that establishes the vehicle is "on the blocks" or is otherwise inoperable. This would also apply to a client's spouse!
9. **Pedestrians** – Remember PLIGA coverage is available only when the client does not have their own or resident coverage and that special forms are required to be sent.

The list could go on and on. Simply put, be ahead of the insurer who is looking for any means to delay and deny coverage in any case where the client is not the insured! Then make sure all proofs go out to the clients' providers – especially their treating physicians. They will eventually be bothering your office asking for it, why not copy and send them the proofs when you send them to the insurer? Always have proof that something is sent. Defense counsel constantly claim that they didn't get things and nothing is more important in PIP than proof of delivery. In fact, every day is a battle over faxes!

Everyday:

1. **Remind the client to send or bring every scrap of paper they receive from the insurer and act on it when necessary.**

For example, if you have sent a letter of representation and your client is still getting documents you are not being copied on, you must immediately write a letter and advise of same. I have won many a case, that I would have otherwise lost, when the patient's attorney has done this.

Two no shows at IMEs will mean a denial of all further benefits if the IMEs were properly noticed. Often insurers do not notify the doctors – even though they are required to. Again, a paper trail is crucial.

2. **Immediately send any IME reports to the providers and immediately write to the insurer demanding a copy of the report when you know your client has attended one.**

As ridiculous as it is, insurers almost never send the providers the IME reports – yet the provider is required to appeal same. When the providers ask for a copy, they are told that the insurer cannot sent it without authorization from the patient. Cut the process short – docket a demand letter that will automatically go out, copy the provider on the letter and send the report when it comes in.

Keep in mind that in many cases the IME cutoff reports are boilerplate mumbo jumbo. However, over and over, we see these reports for the first time. I advise providers to file an appeal, stating they are requesting the report just to get the appeal in and not be barred. Under

the new appeal law, will we suddenly see a provider being barred from introducing evidence to counter the report because the provider failed to get the report when he could have?

3. **Remember MRI centers often send their bills in first and as such, are often the first to be aware of problems.**

Yes, treating providers deal more regularly with the patients and insurers, but that early one time precertification request and EOB denial often is the first sign of problems to come. Any denial other than a straight medical necessity denial will often be a cue to issues that need to be addressed and addressed sooner rather than later.

The Basics of the New Rules

Again, it cannot be said enough that these forms are confusing and the guidance on how they apply to the real world is vague and often unworkable. The providers clearly will have to work around them and I am sure that we will learn more as these cases go to arbitration. This is unfortunate because what will happen is what has happened over and over. Arbitrators will slowly, over time, come to a consensus on what the regulations and forms require. Unfortunately, this will not occur until at least a year or so down the line, until many cases have come before the arbitrators presenting an issue, especially since claims are often not filed for years. This is very common as the insurers come up with issues, often years later, that were unknown at the time.

A very clear example was the fact that a regulation incorporated the Medicare NCCI edits as applicable to PIP. The edits require the use of modifiers to the usual coding of bills. Insurers did not raise the issue of modifiers when the services were being performed and billed and then all of a sudden their counsel woke up and started raising this as a defense years later. Providers lost countless dollars. Dozens of examples of this can be provided. As such, providers must anticipate every possible defense and overcompensate. This cannot be stressed enough.

The below is not meant to be exhaustive and speaks directly to providers. It is to give you, the patients' attorneys a good idea of what needs to be done and to give some preliminary guidance to your clients' providers. Also keep in mind these tips are merely suggestions. The forms fail in many ways and the providers will have to improvise. The regulations also have large gaps and again providers will have to create work-arounds! Again, the key advice here – which in itself shows how ridiculous this attempt is if it is to simplify – when in doubt, file another appeal. When in doubt if something is pre-service or post service – file both. If not sure you need to appeal – do it anyway!

The forms in PDF are found here:

http://www.nj.gov/dobi/pipinfo/preserviceappeal_170208.pdf
http://www.nj.gov/dobi/pipinfo/postserviceappeal_170208.pdf

The forms are also provided in excel (Go to http://www.nj.gov/dobi/pipinfo/aicrapg.htm, scroll down to "Uniform Internal Appeal Forms")

1. The new forms and rules apply to pre-service and post-service appeals that are submitted on or after April 17, 2017. Submission date is the key.
2. The plans will tell how to submit the forms.
3. There are two forms: Pre-service and post-service. According to the Commissioner: "the PIP Post-Service Appeal Form is to be used for an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed as required by the Department's Protocols rule, N.J.A.C. 11:3-4.7B and individual insurer Decision Point Review Plans. It replaces the forms used by individual insurers." (See FAQs referred to above).

Put another way:

A. **Pre-service**: Appeals of DPR and/or precertification denials or modifications prior to the performance or issuance of the service/DME; and

B. **Post-service**: Appeals subsequent to the performance or issuance of the services.

This can be complicated when an insurer untimely denies services, making those services outside the 3-day window deemed approved, thus not part of a medical necessity "pre-service appeal". I specifically objected to it and in the adoption the Commissioner expressly responded stating to do a pre-service appeal for the dates not deemed approved and on the deemed approved services solely send the bill then appeal on the basis they weren't paid as a post service appeal.

What I would do: appeal the denial for all dates and include a specific failure to pay the services that are deemed approved because they were not denied within 3 days in a Pre-service appeal, then do nonpayment on a post appeal. Makes no sense at all, but better safe than sorry. Why include these dates for a medical necessity review? Suppose you lose your fax proof? Suppose they did send a denial within time that your staff missed?

4. Pre-service appeals must be submitted no later than 30 days after receipt of denial or modification. **Don't wait. Things get lost and forgotten. Can a tightly run physician's practice perhaps benefit by waiting? Yes, but the risk of missing dates is very high.**

5.Post-service appeals 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.

Deal with them right away. If you send them out right when each bill is denied, then you will never get stuck running close to a statute of limitations to file arbitration. More importantly, with so many $15,000.00 policies out there, the longer you wait, the less likely money will actually be left on the policy to pay you!!

6. Insurers have 14 days after receipt of the appeal form to respond to "**preservice** appeals" and 30 days after receipt of the appeal form to respond to "**post-service** appeals." I doubt the new system will in any manner have the insurers that never respond start responding.

7. The Commissioner stated that if you miss an appeal, you can file another precertification request. This of course shows that the Commissioner does not understand medical practice. Appeals are within 30 days, so a treating physician who missed an appeal would already be on his way on the next period's precertification request. If the services are one time, like a diagnostic test, missing an appeal date and filing another request will delay care for at least a month and 6 days!! So much for not interrupting care!

8. Uncertainty that the regulations are really what they mean. One commenter requested confirmation from the Department that in accordance with N.J.A.C. 11:3-4.7B(a), DPR Plans may also contain additional requirements to assist insurers in obtaining information needed to review and process appeals efficiently as long as they are not in conflict with the Department's rule. The commenter spoke about including the filing of an appeal within 180 days of an adverse decision and at least 45 days prior to initiating arbitration and submission of a fully completed appeals form with all substantiating documentation. The Commissioner responded:

> The Department does not agree with the commenter that the additional language is necessary. The language of the rule already states at N.J.A.C. 11:3-4.7B(a) that the internal appeal procedure shall meet the requirements of this rule, which permits insurers to include other provisions in their internal appeal procedure that do not conflict with the requirements of this rule.

As such, it is unclear that 45 days before filing arbitration is really what the plans will include as they may throw in different provisions stating that they must be filed within a certain period after the determination. A "standard procedure" is unlikely.

9. While the Commissioner states the providers do not need to provide information already provided, ("Q: When supplying documents indicated in section 29, should the Provider/Facility include a copy of the original associated/supporting records? A: No, when supplying the documents indicated in section 29, the Provider/Facility would only need to supply associated/supporting records if they are <u>new/in addition to</u> the original associated/supporting records supplied." See Faqs, above) the forms do require previous documents to be sent.

10. What to do when there is no response to a precertification request. Who knows?

The Commissioner states as follows:

> Q: What does section 32, "Response not received within 3-business days" mean? I thought that if the insurer doesn't respond to a DPR or precert request within 3 business days, the treatment or test is approved?
>
> A: Some providers submit APTP forms when they have not received a response as appeals. The box allows this to be indicated.

I honestly have no clue what the Commissioner means here and have never heard of a provider doing what the Commissioner claims. Appeal timelines relate to when responses are received, so it would make sense that if there is no response, there is no need to appeal. Again, to be safe, the provider should do a pre-service appeal noting the failure to respond. Again, a savvy office could wait to the end of the appeal period – since inevitable denials will come- but be careful not to be late!

11. The post service appeal form requires specific codes why services were denied and that the provider individually state each code and date. The form then attempts to make it "easier" by having line item reasons and overall reasons. The only real insight found it the FAQs is as follows:

    Q: If a Provider/Facility cannot fit all the services in the lines provided on the Post-Services Appeals Issues (sections 34-38), what do they do?

    A: The requesting provider/facility can use an additional form and complete only the Post-Services Appeals Issues (sections 34-38) on the second form. Use the "Documents Included" (section 29) on the original form and choose "other supporting documents box" to indicate a second page is attached and was required to complete the submission.

    To reduce the need for a second form, the Department recommends the requesting provider/facility providers should only include the lines on the bill that they are appealing.

    Q: What is the best way to indicate the use of more than one code in sections 33 & 38?

    A: The Department would recommend the following:

    If the codes are in a range with no skip in between use a dash (-), if there is a skip in a range or between ranges use a comma (,).

    Examples: A, B, C, D, F, I, J & K would be displayed as A-D, F, I-K

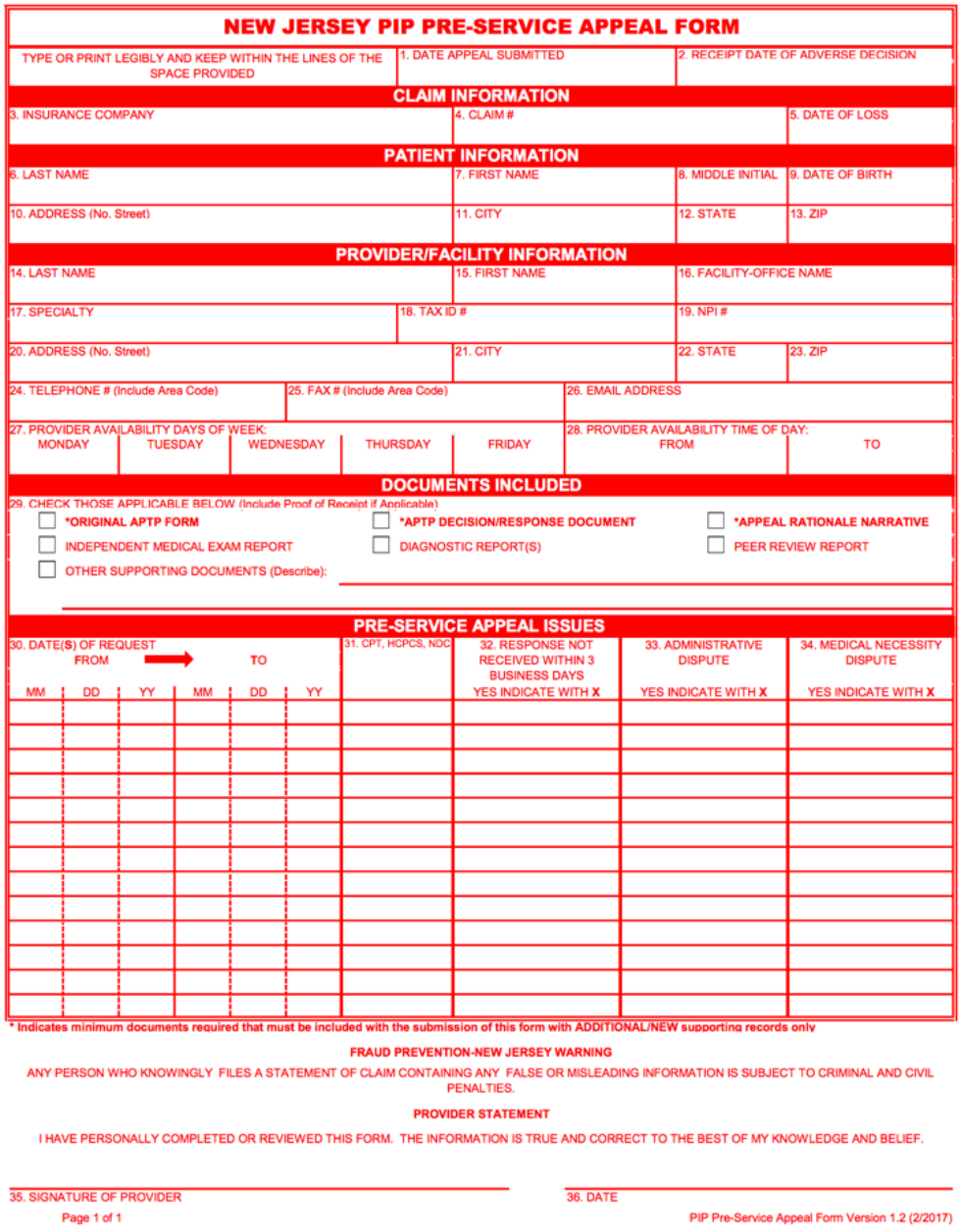
    The answer here is:

    - List all possible issues, use extra pages and the like. Insurers will not like your additions, but when it goes to an arbitrator they will understand the limitations of the form. Make sure all issues are appealed so they are not considered waived for arbitration purposes.

    - Be sure to include everything you can in your appeals

12. The forms in detail:

Pre-service:



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

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PIP Pre-Service Appeal Form Version 1.2 (2/2017)

The top of the form is pretty straightforward. A strange addition is the provider's availability found in Box 27.

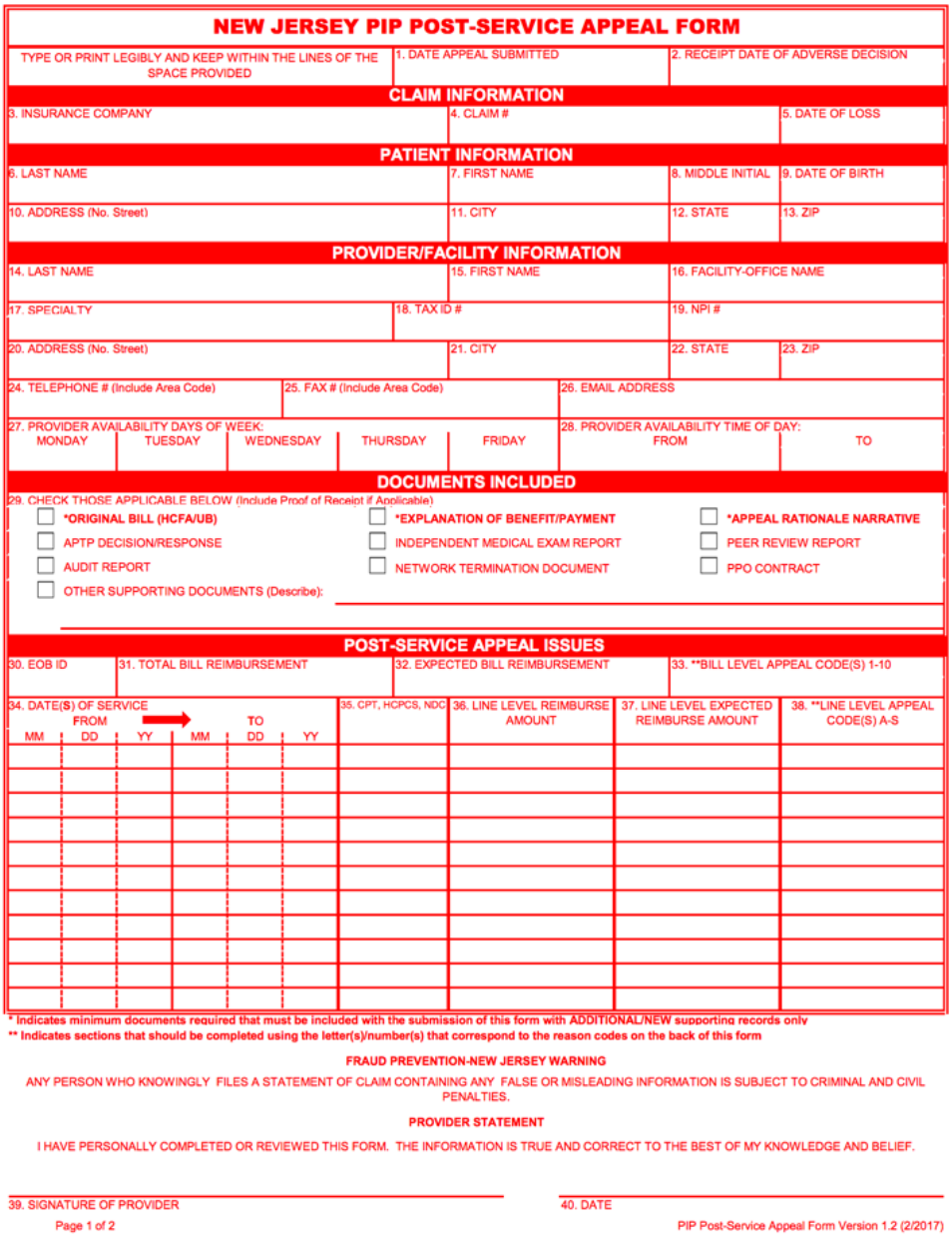
Note that "Required Documents" to be included in Box 29 include the original ATPT form, the Insurers Response and an Appeal Rationale Narrative – a written document from the provider.

Why are you required to include their original denial? Don't they have it? Suppose you did not get a denial?? What is an "administrative dispute?" This really makes no sense as the plans and rules generally require that if you failed to include documents or they administratively deny and ask for additional documents that the process is to supply them and that the request is

not considered complete until that is done. The unanswered question is whether now administrative denials regarding paperwork must now be appealed, rather than documents just being supplied.

More worrisome is if the insurer makes some claim such as coverage being determined or the claim being under investigation. Under the regulations, all decisions regarding precertification must be made by a medical provider. Will insurers try to claim that these are administrative denials that a provider failed to appeal with a precertification appeal?

Post Service Appeals



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

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

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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

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NEW JERSEY PIP POST-SERVICE APPEAL REASON CODES

	BILL LEVEL APPEAL CODES		LINE LEVEL APPEAL CODES
1	Improper Deductible Applied	A	Improper Application of Fee Schedule Amount
2	Improper Co-pay Applied	B	Improper Application of Modifier Reduction
3	Improper Interest Applied	C	Improper Application of Multiple Reduction Calculation
4	Interest Due - Payment Not Made Timely	D	Improper Application of Daily Max Cap Calculation
5	Bill Processed Under Wrong Patient	E	Improper use of National Correct Coding (NCCI)
6	No Response To Bill Submitted Post 60 Days	F	Improper Application of U&C Amount
7	Improper Application of Coordination of Benefits	G	Improper Application of PPO Amount
8	Improper Use of PPO - Not Participating In Network	H	Improper Application of Pre-cert Penalty Co-pay
9	Improper Use of PPO - Terminated From Network	I	Improper Application of Voluntary Network Penalty Co-pay
10	Improper Denial Based on Coverage Investigation	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

The Commissioner has basically recommended one appeal per bill. Again, you are required to send your original bill, their EOB and a narrative.

While this might be simple for something like an MRI, it is not for a treating provider, doing several services which are not necessarily the same each day and which are denied for several reasons. The only guidance for simplication by the Commissioner again is the following:

> If the codes are in a range with no skip in between use a dash (-), if there is a skip in a range or between ranges use a comma (,).
>
> Examples: A, B, C, D, F, I, J & K would be displayed as A-D, F, I-K

Since providers are not always sure – based upon EOBs or complete non-payment – more is better. Better to include a code that leave it out and be barred.

Some of these are still very difficult. Especially the right column:

1. Improper modifier reduction and improper use of NCCI edits often present with the same code.
2. Improper application of the cap is often a hidden nonpayment basis or is stated as a basis when it is not. Others times it is part of a complex basis that includes application of the edits or even mixed with a precertification penalty. I often see EOBs where they claim a service was not precertitifed when it was, throw out codes they should have paid under the NCCI edits, then pay half of the remaining codes. The result is not a simply half pay of the daily cap. When in doubt, throw it in.
3. Improper use of voluntary network penalty. If subjected to this – often it's unclear as the EOBs simply throw it in with penalty co-pays for lack of precertification – appeal it. It's an additional 30% deduction. Many rules

require advisements of the network and certain plans make it impossible to have a network provider provide services unless the services are approved. Keep proofs regarding same and make sure to appeal.

4. Bill audit reduction – what is this? I have no idea.
5. IME reduction. Again obviously this would apply to all services that are specifically denied stating denied per IME. However, in many cases the denials will not say this or will simply say denied as medically unnecessary. In other cases, you might not even know the services were denied per IME. When in doubt – throw it in.
6. Improper application of missing documents – Be careful here. Many insurers craftily word a denial of medical necessary as being "insufficient documentation to support the services". In hearings, I often find myself faced with defense counsel claiming documents were not sent, when what is meant is allegedly the peer reviewer didn't find the documents sent supportive. Again – when in doubt – throw it in.
7. Data Capture Error- Again what does this mean. If the adjuster skipped a day would this be included here? I suppose so. When in doubt…
8. No response to services billed. When they ignore your bill you need to appeal.

Now remember that although you do not have to resend everything you sent before, you really might have to:

1. Improper Precertification Penalties. They are claiming they didn't get it. You would be wise to send the proof of precertification with the appeal.
2. Insufficient medical documentation – send it again so they cannot claim they didn't get something.

Also this is certainly your last opportunity to send anything the PIP attorney might need to send in arbitration. This includes:

1. Any proofs establishing coverage.
2. Any medical proofs from other medical providers that might support your care. PTs for example, really need to send documents from a treating orthopedic surgeon.
3. Any responses to fraud allegations.
4. If they finally sent an IME report, a response to it.
5. Any healthcare primary proofs.

Keep in mind that providers are not expected to be lawyers, thus legal briefing is not required. However, the factual documents to support things should be supplied in advance. Unfortunately, many providers' offices do not recognize legal type issues when they arise. Providers unfortunately have to get savvier and truly understand the myriad of laws that are applicable. Patients' attorneys have to work closely with the providers to make sure they understand the rules and laws and truly should work as a team with PIP attorneys. Only then, will patients and providers be able to get the compensation they are entitled to.