

PRACTITIONER/PROVIDER ADMINISTRATIVE CLAIM RECONSIDERATION AND APPEAL PROCESS

Policy Number: APPEALS 020.11 T0

Effective Date: January 1, 2019

Table of Contents	Page
INSTRUCTIONS FOR USE	1
APPLICABLE LINES OF BUSINESS/PRODUCTS	1
PURPOSE	1
DEFINITIONS	1
POLICY	1
PROCEDURES AND RESPONSIBILITIES	2
REFERENCES	4
POLICY HISTORY/REVISION INFORMATION	4

Related Policies

- [Member Administrative Grievance & Appeal \(Non UM\) Process & Timeframes](#)
- [Timeframe Standards for Benefit Administration Initial Decisions](#)

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

PURPOSE

To outline the process and timeframes for participating Practitioner and Provider administrative claims appeals brought on their own behalf.

DEFINITIONS

Administrative Appeal: Is a request to reverse an administrative (non-clinical, non-utilization management) claims determination including, but not limited to, payment amount of claims, benefits coverage, Member eligibility, privileging, or missing referrals.

Practitioner: A licensed or certified individual who provides health care services, i.e., physicians, nurse Practitioners and specialists.

Provider: An institution or organization that provides services to Members, i.e., hospitals, skilled nursing facilities and home care agencies.

POLICY

This policy incorporates compliance and regulatory standards as well as contractual agreements with participating Providers and Practitioners to set forth their rights to reconsideration and appeal of administrative claims determinations.

Pre-Appeal Claim Review

Before requesting an appeal, if Practitioners or Providers need further clarification of a payment determination, they may contact the health plan, verbally or in writing, for a review of the claims payment issue. The health plan will make every effort to clarify or explain Oxford's actions. If the health plan determines that additional payment is justified, Oxford will reprocess the claim and remit the additional payment.

Who Can Submit a Reconsideration or Appeal

Participating Providers or Practitioners appealing a decision on their own behalf.

Note: Any Provider or Practitioner appealing a decision on behalf of the Member, must provide signed Member consent and must follow the process for Member administrative claims appeals. Refer to the policy titled [Member Administrative Grievance & Appeal \(Non UM\) Process & Timeframes](#) for additional information.

Timeframe for Submitting a Reconsideration or Appeal

Claim Reconsideration and Appeal Process

Requests for reconsideration and/or appeal of administrative claims determinations must be submitted within 12 months of the date on the initial Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). The two step process described below allows for a total of 12 months for timely filing

Important Note: The reconsideration level and the appeal level share one 12-month timeframe. If an appeal is submitted after the time frame has expired, Oxford will uphold the denial.

Exceptions: There are separate processes for the following appeal types. Click the link for additional information.

- [New Jersey Participating Providers](#)
- [Unilateral Coding Adjustments for NY Hospitals](#)

- 1. Step One – Reconsideration Level:** Participating Provider and Practitioner reconsideration requests must include the [Participating Provider Request for Commercial Members' Claim\(s\) Review Request Form](#) and all supporting documentation. If the reconsideration does not result in an overturned decision, the EOB or response letter will include next level rights and where to submit a request for further review.
- 2. Step Two – Appeal Level:** Participating Provider and Practitioner appeals must be submitted in writing within the same 12 month time frame, as stated above. The appeal must include all relevant documentation including a letter requesting a formal appeal and a Claim Review Request Form.

New Jersey (NJ) Participating Provider Appeal Process

NJ Participating Providers are subject to the NJ State-regulated Appeal Process. If a NJ participating Provider has a dispute relating to payment of a claim involving a NJ commercial Member, the dispute is eligible for an individual 2 step process.

- **First Level: The first level appeal is made through Oxford's internal appeal process. A written request for appeal must be** submitted via the [Health Care Provider Application to Appeal a Claims Determination Form](#) created by New Jersey Department of Banking and Insurance. This appeal must be submitted within 90 days of the date on Oxford's initial determination notice to:

UnitedHealthcare
Attn: Provider Appeals
P.O. Box 29136
Hot Springs, AR 71903

The review will be conducted and results communicated to the Provider in a written decision within 30 calendar days of receipt of all the material necessary for such appeal.

- **Second Level:** The second level appeal must be made through the external dispute resolution process. If a NJ participating Provider has completed the internal appeal process and is not satisfied with the results of that internal appeal, the Provider has the right under the Provider's contract to arbitrate the dispute with Oxford. Providers should submit their request to:

MAXIMUS, Inc.
Attn: New Jersey PICPA

50 Square Drive, Suite 210
Victor, NY 14564
Fax: (585) 425-5296
(MAXIMUS, Inc. requests that faxes be limited to 25 pages.)

Providers may also consult their contract to determine the appropriate arbitration authority. Most contracts provide for arbitration before the American Arbitration Association (AAA). The costs of arbitration are borne equally by the participating Provider and Oxford, unless the arbitrator determines otherwise. The decision in such arbitration is binding on the participating Provider and Oxford, pursuant to the terms of the Provider agreement. To commence arbitration, the Provider must file a statement of claim with the AAA at the address listed in the [Arbitration](#) section below.

Unilateral Coding Adjustments for New York (NY) Hospitals Appeal Process

If a NY hospital receives a PRA /payment indicating that Oxford has adjusted payment based on a particular coding to a patient (i.e., assignment of diagnosis and or CPT/HCPCS or other procedure code), the hospital has the right to resubmit the claim, along with the related medical record supporting the initial coding of the claim, within 30 days of receipt/notification of payment.

Oxford must review the medical records within the normal review timeframes (45 days). If Oxford's initial determination:

- **Remains unchanged**, the insurer's decision must be accompanied by a statement providing the specific reasons why the initial adjustment was appropriate.
- **Changes** and the payment is increased based on the information submitted by the hospital, Oxford must provide the additional reimbursement within the 45 day review timeframe.

If Oxford fails to provide the additional reimbursement within the 45 day review timeframe, Oxford must pay to the hospital interest on the amount of the increase. The interest must be computed from the end of the 45 day period after resubmission of the additional medical record information.

Note: Neither the initial or subsequent processing of the claim by Oxford may be considered an adverse determination if it is based solely on a coding determination.

Method for Submitting a Reconsideration or Appeal

Written Appeals

Utilize Oxford's [Participating Provider Request for Commercial Members' Claim\(s\) Review Request Form](#) to determine the appropriate mailing address.

Note: There are separate processes for the following appeal types:

- Internal and external claims payment appeals for NJ participating Providers who treat NJ commercial Members. See [New Jersey State-regulated Appeal Process for New Jersey Providers](#).
- The appeal of unilateral coding adjustments made to NY Hospital claims. See [Appeal Process for Unilateral Coding Adjustments for NY Hospitals](#).

Appeal Decision and Resolution

Full documentation of the substance of the appeal and the actions taken will be maintained in an appeal file (paper or electronic). Written notification to the Provider will be issued via letter or updated RA statement at the time of determination of the appeal.

This decision will constitute Oxford's final internal decision. If the Provider is not satisfied with Oxford's decision, they may arbitrate the issue. Refer to [Timeframe Standards for Benefit Administrative Initial Decisions](#) for additional information.

Arbitration

Filing for Arbitration

If the physician or Practitioner wants to file for arbitration after the first level appeal has been completed, the physician or Practitioner must file a statement of claim with the AAA at the following address:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue 4th Floor
East Providence, RI 02914
Phone: 1-800-293-4053

Providers located outside of NY, NJ and CT should refer to the AAA web site (<http://www.adr.org>) for submission guidelines.

Participating Physicians

Participating physicians who are appealing an adverse determination are entitled under their Provider contract to bring the issue before the American Arbitration Association (AAA). They have this right only under the following circumstances:

- The 1st level internal grievance process has been completed.
- The appeal is on their own behalf (not on behalf of the Member).

Participating Hospitals and Ancillary Facilities

Participating hospitals and ancillary facilities also have arbitration rights but those rights vary depending on the contract. If a hospital or ancillary facility calls to inquire about arbitration rights, they should be referred to their contract for the specific arbitration entity. Hospitals and ancillary facilities still must utilize the 1st level internal appeal process.

REFERENCES

UnitedHealthcare Provider Administrative Guide including Oxford Commercial Supplement available at: www.uhcprovider.com/guides

ERISA - 29 C.F.R. §2560.503-1.

NCQA Health Plan Accreditation Standards.

NJ Prompt Pay regulation - N.J.A.C. 11:22-1.8.

NY Senate Bill 7071, Section 4.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	<ul style="list-style-type: none">• Updated supporting information to reflect the most current references; no change to policy guidelines• Archived previous policy version APPEALS 020.10 T0