

## Overview

If you ever disagree with any of WellChoice's policies or services or would like to request a review of an unfavorable determination, you may file a complaint, grievance or appeal. Please refer to the information below in order to follow the proper procedures.

## Provider Complaints

A complaint is an expression of dissatisfaction with any aspect of WellChoice's healthcare services not involving a plan decision.

If the Hospital is dissatisfied with any aspect of WellChoice's policies or practices relating to the delivery of services to Covered Persons they may file a complaint with WellChoice. To do so, the Hospital may contact WellChoice's Provider Services Department by telephone or in writing. (No specific form for written complaints is required.)

By mail:

WellChoice  
PO Box 3509  
Church Street Station  
New York, New York 10008-3509  
Attn: Provider Services

By phone:

1-888-476-7245, Monday – Friday,  
8:30 a.m. to 5:00 p.m.

The complaint and any supporting documentation submitted by the Hospital will be internally investigated by a Provider Services representative and the results will be communicated in a written decision to the Hospital within 30 calendar days of receipt of the complaint.

This process applies to instances in which WellChoice is not being asked to review or overturn a previous administrative or medical management decision resulting in a claim denial, reduction in claim payment, or denial of preauthorization or certification of covered services. The processes used for those types of issues are described below.

## Grievances

Grievances are requests to review unfavorable decisions (also called adverse determinations) not based upon medical necessity (e.g., benefit limitation, delay in service, subscriber contract exclusion, etc.). You must file a level one grievance within 180 calendar days from the date of our initial determination. Grievances filed after that date will not be considered.

To file an internal grievance, call or write to WellChoice Provider Services at the address indicated above.

WellChoice will investigate and respond to grievances about the processing of a claim within 10 business days of receipt of the grievance. WellChoice will respond to all other grievances within 60 calendar days.

In the case of an urgent medical need where a delayed decision would significantly increase the risk to a patient's health, WellChoice will render a decision faster. In this situation the Hospital can request an expedited grievance.

Expedited grievances will be responded to within 72 hours of WellChoice's receipt of the grievance.

If the grievance decision concerning the processing of a claim is adverse, WellChoice will include a description of the method the Hospital may follow to obtain an external review of the grievance decision in accordance with New Jersey law and regulation as described below.

## External Provider Claim Grievances

If the Hospital is dissatisfied with the result of an internal grievance concerning the processing of a claim, it may file an external grievance through an independent party pursuant to an alternative dispute resolution (ADR) mechanism established by WellChoice. The cost of the process shall be borne equally by both the Hospital and WellChoice. The recommended decision of the external review party, which shall not be binding unless the parties otherwise agree, will be issued no later

than 30 business days from receipt by the ADR firm of a complete grievance request and all information necessary to properly resolve the external grievance. This procedure does not apply to appeals initiated by providers who are dissatisfied with a medical management determination made by WellChoice.

The ADR mechanism is as follows:

The Hospital will receive an External Grievance Request Form with all adverse grievance determinations resulting from a first stage internal grievance. To initiate an external grievance, the Hospital shall submit the request form to The Center for Health Dispute Resolution, the designated external claim grievance agent responsible for second stage grievances relating to claims adjudicated by WellChoice. The request form should be mailed to:

The Center for Health Dispute  
Resolution/MAXIMUS  
Attn: New Jersey Provider Grievance  
Department  
1 Fishers Road 2<sup>nd</sup> Floor  
Pittsford, NY 14534

The Hospital may also obtain a copy of an External Grievance Request Form from WellChoice's Provider Services Department by calling 1-888-476-7245 Monday – Friday, 8:30 a.m. to 5:00 p.m. An external grievance may only be initiated after completion of the internal claim grievance process described above.

The external reviewer will function as a wholly independent party with no affiliation with WellChoice or the Hospital other than to function as an external grievance agent for this purpose. The external reviewer's external grievance investigation and recommendation will be based on his or her review of the claim grievance, with no input or influence from WellChoice. WellChoice and the Hospital will share the cost of the external grievance performed by the external reviewer.

If the Hospital wishes to initiate an external grievance, the Hospital shall submit the

completed External Grievance Request Form to the external reviewer within 60 calendar days of receipt of WellChoice's internal grievance denial, along with a \$25 initial processing fee, representing 50% of the initial processing fee. WellChoice will be responsible for the other \$25 payment due to the external reviewer. The request form submission may include any supporting documentation the Hospital elects to submit in support of the external grievance request. Such documentation may include medical records, provider contract provisions, communications received from WellChoice during the claim adjudication process and care delivery process and any other information the Hospital deems relevant.

The external grievance determination made by the external reviewer will not be binding on either the Hospital or WellChoice unless both parties agree. The Hospital will have the opportunity to indicate a preference regarding the binding nature of the External Grievance on the request form. The external reviewer will notify the Hospital if WellChoice agrees to the Hospital's request prior to the commencement of the investigation phase of the external review. In the absence of such agreement, the external grievance determination will not be binding on the parties.

Medical records should be submitted by the Hospital in support of the external grievance request only if and to the extent the Hospital reasonably believes the records are relevant to the claim grievance. In transmitting medical records or other data or information pertaining to the diagnosis, treatment or health of the patient, the Hospital shall comply with all applicable federal and state laws and regulations pertaining to the confidentiality and privacy of patient medical information.

The external reviewer will fax to the Hospital confirmation of its receipt of the request form and supporting documentation and request any additional information needed to evaluate

the external grievance within two business days of its receipt of the request form.

The Hospital will be required to respond to requests for additional information as described above within 15 business days of receipt of the request.

WellChoice will submit supporting documentation relating to the grievance to the external reviewer as it deems appropriate and as requested by the external reviewer.

Upon the external reviewer's receipt of all supporting documentation from the Hospital and WellChoice deemed necessary by the external reviewer to evaluate the external grievance, the external reviewer will determine the estimated cost of the external grievance review and resolution and notify the Hospital in writing of the cost. The Hospital shall be responsible for remitting fifty percent (50%) of the estimated cost of the review within 10 business days of receipt of the request if the Hospital wishes to proceed with the external grievance. It is generally estimated that the Hospital's responsibility for the external grievance costs will be between \$100 and \$300, plus the \$25 processing fee. However, depending on the complexity of the grievance, the Hospital's financial responsibility may be higher.

If the Hospital does not remit the amount payable within the requested time frame, the external grievance will be dismissed. In such an event, the Hospital may elect to reopen the external grievance by submitting the required payment or any outstanding documentation requested by the external reviewer within 10 additional business days.

Within 15 business days from the date of receipt of all requested information and payment by the Hospital, the external reviewer will complete the External Grievance Review and provide a written recommendation to the Hospital and WellChoice.

Unless the parties have agreed that the external reviewer's determination will be binding on the parties, neither WellChoice nor the Hospital will be required to follow the external reviewer's recommendation regarding the grievance's resolution.

If the external reviewer's recommendation is that WellChoice pay the disputed claim payment at issue, and the parties have agreed that the external reviewer's recommendation will be binding on the parties, or WellChoice voluntarily agrees to follow the external reviewer's recommendation, WellChoice shall remit the claim payment due to the provider within 10 business days of WellChoice's receipt of the external reviewer's recommendation. WellChoice will include with the claim payment to the Provider interest due under N.J.A.C. 11:22-1.6 in accordance with the external reviewer's decision. The decision as to whether interest shall be payable will depend on whether the external reviewer's decision that the claim should be paid is based on information that was submitted to WellChoice during the initial claim adjudication process.

If the external reviewer's recommendation is that WellChoice pay the disputed claim payment at issue and the parties have not agreed that the external reviewer's recommendation shall be binding on the parties and WellChoice does not agree to follow the external reviewer's recommendation, WellChoice shall notify the Hospital of its decision not to follow the External Reviewer's External Grievance recommendation, within 10 business days of WellChoice's receipt of the external reviewer's recommendation.

## Appeals

If WellChoice Medical Management determines that an admission, extension of a Hospital stay, or some other healthcare service is not medically necessary, you may request an appeal of the decision in the following manner, provided you are acting on the member's behalf and with the member's consent.

The following can be appealed through WellChoice:

- Our initial adverse decision
- Our decision following a standard Stage One appeal
- Our decision following an expedited Stage One appeal

WellChoice offers two stages of appeal for members (and for providers acting on behalf of the member with the member's consent.)

Stage One appeals must be initiated within 180 days of our initial decision. Appeals filed after that date will not be considered, and you will receive a letter stating that the opportunity to file an appeal has been exhausted. The appeal should be accompanied by a letter stating why the determination is being appealed and why it should be overturned, as well as the information necessary to review it, such as the Hospital chart.

An appeal is initiated by calling or writing to the WellChoice Medical Management Appeals Department at 1-800-634-5605 Monday – Friday, 8:30 a.m. to 5:00 p.m. or writing to:  
WellChoice  
PO Box 3509  
Church Street Station  
New York, New York 10008-3509  
Attention: Appeals Department

If sufficient documentation to support the reasons for the appeal was not provided, the WellChoice Appeals Department will request additional documentation or medical records. When these are received, the case is reviewed by a physician of the same or similar specialty as the provider who would typically manage the case at issue.

If we make a decision favorable to the person filing the appeal, written notification is sent stating that the initial denial decision has been reversed. If we make a final adverse decision upholding our prior decision, we will provide written notification that includes the clinical rationale upon which the appeal

determination is based. The letter will also contain information and rights regarding filing a request for a Stage Two appeal to WellChoice.

If you have requested an internal review of an adverse decision and we have not made and notified you of our review decision within five business days, the appellant is entitled to proceed directly to an external appeal with the State of New Jersey.

### **Expedited Appeals**

The facility, acting on the member's behalf, may request an urgent/expedited appeal to be implemented when the denial of coverage involves any of the following:

- Cases involving continued or extended healthcare services
- Requests for additional services for a patient undergoing a continuing course of treatment
- Any case in which the member's physician or healthcare provider believes an immediate appeal is warranted

Note: Retrospective appeals are not eligible to be expedited.

We will provide reasonable access to a Medical Director within one business day of receiving notice of the request for an expedited appeal. WellChoice will make its determination on an expedited appeal and notify you of the decision within 72 hours of receipt.

Expedited appeals that uphold our prior decision may be further appealed through the Stage Two internal appeal process, on an expedited or standard basis.

### **Stage Two Appeals**

If you are dissatisfied with our decision on the Stage One appeal, you may, with the member's consent, request a second appeal. This is referred to as a Stage Two appeal. You have 60 calendar days from the date of our decision on the initial appeal to file a Stage Two appeal. WellChoice will send a written acknowledgement of the appeal to the

appellant within 10 days of receipt of the appeal.

The Stage Two appeal will be reviewed by a panel of physicians and/or other healthcare professionals who have not been involved in the adverse determination at issue.

WellChoice has consultants available and will ensure that a physician or healthcare provider of the same specialty as the provider who would typically manage the case at issue is available, if the member requests this for the panel hearing.

Stage Two appeals are completed within five calendar days of receipt for prospective appeals and 20 business days of receipt for retrospective appeals. In certain circumstances, WellChoice may extend the review for an additional 20 days. If such an extension is taken, the appellant and the State of New Jersey are informed of the reason(s) for doing so. WellChoice will make its determination on an expedited appeal within 72 hours of receipt.

If the decision is upheld, in whole or in part, a determination letter is sent to the appellant that includes the clinical rationale for the denial, and the right to proceed to an external appeal with the State of New Jersey. An application form and instructions for filing an external appeal are included with the determination letter.

### **External Appeals**

Under certain circumstances, if you are not satisfied with the outcome of an internal medical necessity appeal, you may have the right to file a request with the State of New Jersey for an additional review by an independent third party (“external appeal”).

Requests for external appeals must be filed with the State of New Jersey within 60 calendar days of receiving a Stage Two adverse determination. We do not have the authority to grant extensions of this deadline.

Forms and instructions for filing an external (Stage Three) appeal are included with the Stage Two adverse determination letter.

### **Stage Three Appeals**

The Stage Three appeal is a formal review by an independent utilization review organization (IURO) assigned by the New Jersey Department of Health and Senior Services. If the IURO determines that the denial, reduction or termination of benefits deprived the member of medically necessary covered services, it will advise the member and WellChoice of its decision regarding the appropriate, medically necessary healthcare services that the member should receive, and this decision will be binding on WellChoice. WellChoice will promptly provide coverage of the healthcare services found by the IURO to be medically necessary covered services. If the member does not agree with the IURO’s decision, he or she may independently seek the desired healthcare services at his or her own expense.

### **Behavioral Health Care Appeals**

To request an appeal of an initial behavioral health care medical management determination, please submit your request to:

Appeals Department  
Magellan Behavioral Health  
199 Pomeroy Road  
Parsippany, NJ 07054

Should you and your patient not be satisfied with the Stage One determination, please follow the procedure outlined in the Appeals section of this *Sourcebook*. Submit your request to:

WellChoice  
PO Box 3509  
Church Street Station  
New York, New York 10008-3509  
Attention: Appeals Department

Send behavioral health related complaints or grievances not relating to Medical Management appeals to:

Complaints  
Magellan Behavioral Health  
199 Pomeroy Road

Parsippany, NJ 07054  
or call 1-800-626-3643.

For information regarding claims, or claim disputes, call our Provider Services Line at 1-888-476-7245 Monday – Friday, 8:30 a.m. to 5:00 p.m.

### Our Additional Responsibilities

In addition to all of the previously stated responsibilities, we will also

- protect the confidentiality of all parties involved in the complaint and appeals process.
- allow a member to appoint a representative to act on his/her behalf at any point during the grievance and appeals process.
- include information regarding the next available level of appeal into all adverse responses to appeals.