PIP STEPS FOR APPEAL & ARB PROCESS

- Please note in Medevolve the denial reason and the DOS that is being denied, also if only a partial payment is made and a portion of the bill was not paid it will need to be appealed. Please note where the denial EOB is being scanned and saved to into Medevolve as well
- Save EOB denials into > Ebridge > under client, patient name,and EOB **(if you don't have one, create it) > save the denials by the date that the note is entered in Medevolve- 062918< should show as the file name if notes are entered on June 29, 2018 into Medevolve.**

****

PLEASE NOTE HEALTH CARE PRIMARY DENIALS FROM MV DO NOT COME TO ME THEY SHOULD BE HANDLED BY THE ACCOUNT REP!

PIP denial - Appeal reasons

1. IME DENIALS AND/OR TERMINATIONS
2. MEDICAL NECESSITY
3. EXCEEDS FEE SCH ALLOWABLE AMOUNT
4. PEER REVIEW
5. MISSING SUPPORTING DOCUMENTS
6. IF BILL IS OVER 60 DAYS FROM "SUBMITTED DATE" AND NO EOB HAS BEEN RECEIVED
7. PRECERT PENALTIES < only if applicable
8. IF THE BILL IS PARTIALLY PAID (meaning some codes may have been paid while others were not on that same DOS)< this HCFA should be given to me

****If any other reason I may have not listed please ask me if you are unsure****

Precert penalty bills should only be on the shelf for appeal if you "account rep" have already checked and confirmed that the Dr's office did in fact send a Precert on time with the correct date range and codes. If the DOS is (11/5/17-code 99213) the Precert also known as "Attending Provider Treatment Plan" should have the codes we billed for on them
I have attached an example for you

POLICY EXHAUSTED OR POLICY LIMIT MAXED - means there is NO $$$ to collect - NO ARB NO APPEAL CAN BE DONE.

At this point the account reps need to find out if the patient has health insurance that can be billed as secondary or an attorney

IF A DENIAL STATES PATIENT **IS NOT ELIGIBLE FOR BENEFITS** you must call the attorney if one is on file and find out if there is another insurance that can be billed. (Ask for a LOP if one is not on file) If no attorney > Bill patient

IF DENIAL STATES PATIENT HAS MISSED 2 IME'S (INDEPENDENT MEDICAL EXAM) – you must call the attorney as well, advise them of the situation and move forward with what they explain to (in this case ask for a LOP if one is not on file)

*****PLEASE UNDER NO CIRCUMSTANCE SHOULD MEDICARE BE BILLED WHEN IT IS A MVA ***- if you are dealt with Medicare being your secondary for a MVA please come to me**

If there is health secondary that can be billed please attach the PIP exhaustion letter you received with the office note and MAIL it to the health ins.
If you only have an attorney on file then you must call the attorneys office and advise them the PIP is exhausted and you have no health insurance to bill so you will need a LOP "Letter of Protection" / "Lien" to make sure the doctors balance is protected.

The attorney will advise you as to what you will need to do in order to obtain one from them.

Ledger request from lawyer or anyone else should be handled by **ANYONE** who picks up the phone- take down the patient name , ask for what Dr. and the fax # it should be sent to. Then advise the account rep of the info. < use hang outs or email .

****Unless attorney wants to negotiate a bill for settlement, in that case please give them my email or transfer me the call****
(cmedina@strategicpsonline.com / (Ext 217 / Fax 844-838-5202)
AGAIN PLEASE ONLY SEND THE ATTORNEY MY WAY IF IT'S FOR A SETTLEMENT NEGOTIATION

Again this is only for MVA:
This is the PIP fee sch list link for online. If you are not sure if paid correct as per fee sch please look here
>https://www.state.nj.us/dobi/pipinfo/ex1_130104.pdf

Any questions please email me / or use hang outs.

Thank you
Carmen

Precert Request ↓

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☑ FOLLOW UP SUBMISSION

DATE SUBMITTED: Month 10 Day 04 Year 17

TYPE OR PRINT LEGIBLY

CLAIM #: [redacted]

PATIENT INFORMATION

1. PATIENT'S NAME: [redacted]
2. PATIENT'S ADDRESS: [redacted]
3. CITY: [redacted] 4. STATE
5. ZIP CODE: 07662
6. TELEPHONE # (Include Area Code): [redacted]
7. PATIENT BIRTHDATE
8. SEX: ☐ M ☑ F
9. INSURANCE COMPANY: PROGRESSIVE INSURANCE
10. POLICY NUMBER

11. DATE OF ACCIDENT: 04/20/2017

12. IS PATIENT'S CONDITION RELATED TO:
A. EMPLOYMENT? ☐ YES ☑ NO
B. AUTO ACCIDENT? ☑ YES ☐ NO
C. OTHER ACCIDENT? ☐ YES ☑ NO

13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

14. POLICYHOLDER'S NAME: Last / First / Initial
15. POLICYHOLDER'S ADDRESS (No. Street)
16. CITY 17. STATE
18. TELEPHONE # (Include Area Code) 19. ZIP CODE
20. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

21. NAME OF TREATING PROVIDER (Last)	First	Initial	22. TAX I.D.	23. NPI	24. SPECIALTY	25. FACILITY OR OFFICE NAME
Masri	Sammy	I	-		'ORTS MEDICINE	MASRI Sports Medicine & Wellness

26. FACILITY/OFFICE ADDRESS (No. Street)	27. CITY	28. STATE	29. ZIP CODE
1 [redacted]	CLIFTON	NJ	07011

30. TELEPHONE # (Include Area Code)	31. EMAIL ADDRESS	32. FAX # (Include Area Code)	33. INITIAL DATE OF TX	34. DATE OF LAST VISIT
973-777-0934	N/A	973-773-0543	6/21/2017	10/04/2017

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ MEDICATIONS ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTIC TEST ☐ EXISTING CONDITIONS ☐ COMORBIDITIES ☐ OTHER

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below) ICD Ind. ☐ 9 ☑ 10

A. M79.1 B. M54.2 C. M50.220 D.
E. F. G. H.
I. J. K. L.

37. CHECK APPROPRIATE CARE PATH (if applicable): ☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6 N/A

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

38. DATE(S) OF REQUEST FROM MM	DD	YY	TO MM	DD	YY	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT Purchase	Rental	SPINAL INJECTION Unilateral	Bilateral	DIAGNOSIS POINTER	FREQUENCY	FREQUENCY	DURATION	TOTAL UNITS
11	01	17	11	15	17	99212-99214					ABC	1	1	1	1

DATE range & Codes
*If Not listed 50% Cut will Apply

☐ INCLUDE SUPPORTING DOCUMENTS

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 AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

39 [signature] SIGNATURE OF PROVIDER

10/5/2017 DATE

APTP FORM VERSION 2

↑ This is done by Dr.'s office.

POST SERVICE APPEAL STEPS

- Post service appeal form MUST BE FILLED OUT WITH CORRECT APPEAL CODES
- Narrative
- HCFA's
- EOB'S
- Collect all treatment notes , including OP reports , MRI's , Xrays
- AOB (assignment of benefits)
- Precerts covering the range of DOS you are appealing ONLY
- Auths and/or Denials from the precert request
- PREVICE APPEALS should be included if the decision is different from the actual EOB we received for the bill

(Example: the office sends a Precert for an OV – MV denies the precert stating it's not medically necessary- then the Dr's office sends a Pre-service appeal > they get a denial for the appeal stating denied due to medical necessity again – Once we bill it and our EOB states denied for IME benefits term, a post service appeal must be done because the denial was different from the original precert denial , however if the EOB would have stated denied for Medical Necessity again like the preservice appeal then NO Post service has to be done.

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:					28. PROVIDER AVAILABILITY TIME OF DAY:	
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	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			TO			35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S
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

** 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 ______________________

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