You can change your mind after you've signed a living will. Call your Amerigroup PCP. They will help you take the living will out of your medical record. You can also make changes in the living will by filling out, signing, and dating a new one.

GRIEVANCES AND APPEALS

If you have a grievance
If something isn't working, our team wants to hear about it. Our member grievance and appeal process allows us to get your feedback and make things right. If you have a problem with your medical, dental, or Amerigroup services that do not involve denial of medical benefits, also called non-utilization management or non-UM services, call or write to us. You can also ask your provider and/or an authorized person to call or write to us for you. Contact us at the address and phone numbers below:

Amerigroup Community Care
Quality Management Department
101 Wood Ave. S., 8th Floor
Iselin, NJ 08830
Phone: 800-600-4441 (TTY 711)
Fax: 877-271-2409

A Member Services representative will work with you to try to help fix your problem. If your problem isn't taken care of right away, we'll send you a letter or call you for more information. We will take care of your grievance within 30 calendar days of when we got your call or letter.

If your grievance is urgent, we'll give you an answer within 72 hours of when we receive it.

If you file a grievance, Amerigroup won't hold it against you. We'll still be here to help you get care.

You, your provider, or authorized person can file a grievance orally or in writing with or Amerigroup.

You have the right to file a grievance in your language. If you ask, we'll tell you in your primary language of your rights to file grievances and will give the decision in your primary language. If you need help filing a grievance in your language, call Member Services at 800-600-4441 (TTY 711).

How to file a grievance

Level 1 grievance
To file a non-UM (Utilization Management) or non-medical grievance, you, your provider, or authorized person can call us, write to us, or send us a fax if they have your written consent. Tell us the problem, when it happened, and the people involved. Contact us at the address and phone numbers below:

Amerigroup Community Care
Quality Management Department
101 Wood Ave. S, 8th Floor
Iselin, NJ 08830
Phone: 800-600-4441 (TTY 711)
Fax: 877-271-2409

Once we get your grievance, we'll send you (and your provider or authorized person, if they made the request with your written consent) a letter within 15 calendar days to let you know we have your grievance. We'll ask you for more information, if needed. We'll try to solve the problem so you're satisfied.

We'll then send you (and your provider or authorized person, if they made the request with your written consent) a letter to let you know what our decision is within 30 calendar days from when you contacted us about your grievance. You can file another grievance with us about this problem if you're still not pleased.

Level 2 grievance
If you're still unsatisfied with the answer you got about your non-UM Level 1 grievance, you or your provider or authorized person has 60 days from the date of our response to file a Level 2 grievance with your written consent. To file a Level 2 grievance, you, your provider, or authorized person can call us, write to us, or send us a fax. Tell us the problem, when it happened, and the people involved. Contact us at the address and phone numbers listed in the last section, "Level 1 grievance."

We'll send you a letter within 30 calendar days of when we got your Level 2 grievance. This letter will tell you the final decision.

Utilization Management
Sometimes, we need to make decisions about how we cover care and services. This is called Utilization Management (UM). The UM process or authorization for care may include looking at requests for health care to see if they are covered. Amerigroup follows the standards set forth by the National Committee for Quality Assurance (NCQA). All UM decisions are based solely on your medical needs and available benefits. We do this for the best possible health outcomes for our members. Our policies don't discourage the use of services through the UM decision process. Providers and UM decision-makers don't get any type of reward if members don't use all the available services, or for denial of care or benefits.

Members can call for information about a specific UM service request. Language assistance for members to discuss UM issues in their primary language is provided, as well as TTY services for members who need them. Call us at 800-600-4441 (TTY 711). Member Services is available Monday to Friday from 8 a.m. to 6 p.m. Eastern time. Our representative will tell you their name, title, and that they work for Amerigroup.

Utilization management appeal process: service denial/limitation/reduction/termination based on medical necessity

You and your provider should receive a notification letter within two business days of any health plan decision to deny, reduce, or terminate a service or benefit. If you disagree with the plan's decision, you (or your provider, with your written permission) can challenge it by requesting an *appeal*. See the summary below for the time frames to request an appeal.

Stages	Time frame for member/ provider to request appeal	Time frame for member/provider to request appeal with continuation of benefits for existing services	Time frame for appeal determination to be reached	NJ FamilyCare plan type
Internal Appeal The **Internal Appeal** is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.	60 calendar days from date on initial notification/ denial letter.	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the notification letter, ***whichever is later.***	30 calendar days or less from health plan's receipt of the appeal request.	A/ABP B C D
External/IURO Appeal The External/IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO).	60 calendar days from date on Internal Appeal notification letter.	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter, ***whichever is later.***	45 calendar days or less from IURO's decision to review the case.	A/ABP B C D
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter, unless the Fair Hearing is for	***Whichever is the latest of the following:*** • On or before the last day of the current authorization; ***or*** • Within 10 calendar days of the date on the Internal Appeal notification letter, ***or***	A final decision will be reached within 90 calendar days of the Fair Hearing request.	A/ABP ***only***

Stages	Time frame for member/ provider to request appeal	Time frame for member/provider to request appeal with continuation of benefits for existing services	Time frame for appeal determination to be reached	NJ FamilyCare plan type
	a provider lock-in adverse deter-mination, then the time frame is 20 calendar days.	• Within 10 calendar days of the date on the External/IURO appeal decision notification letter.		

Initial Adverse Determination
If Amerigroup decides to deny your initial request for a service, or to reduce or stop an ongoing service that you have been receiving for a while, this decision is also known as an *adverse determination*. We will tell you and your provider about this decision as soon as we can, often by phone. You will receive a written letter explaining our decision within two business days.

If you disagree with the plan's decision, you or your provider (with your written permission) can challenge the decision by requesting an *appeal*. You or your provider can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can call the plan at 800-600-4441 (TTY 711) Monday to Friday from 8 a.m. to 6 p.m. Eastern time. Please remember that if your appeal is requested orally, you will need to follow up by sending a written, signed letter confirming your appeal request as soon as you can. Written appeal requests should be mailed to the following address:

Amerigroup Community Care
Appeals Department
P.O Box 62429
Virginia Beach, VA 23466-2429

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

Internal Appeal
The first step of the appeal process is a formal internal appeal to the plan (called an Internal Appeal). Your case will be reviewed by a doctor or another health care professional, selected by Amerigroup, who has expertise in the area of medical knowledge appropriate for your case. We will be careful to choose someone who was not involved in making the original decision about your care. We must make a decision about your appeal within 30 calendar days (or sooner, if your medical condition makes it necessary).

If your appeal is denied (not decided in your favor), you will receive a written letter from us explaining our decision. The letter will also include information about your right to an External Independent Utilization Review Organization (IURO) Appeal, and/or your right to a Medicaid State Fair Hearing, and how to request these types of further appeal. You will also find more details on those options later in this section of the handbook.

Expedited (fast) Appeals
You have the option of requesting an expedited (fast) appeal if you feel that your health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about your appeal. Also, If your provider informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize your life or health, or your ability to fully recover from your current condition, we must make a decision about your appeal within 72 hours.

Phone: 800-600-4441 (TTY 711)
Fax: 877-271-2409
Email: nj1memappeals@amerigroup.com
Mail/In-Person: 101 Wood Ave. S., 8th Floor
Iselin, NJ 08830

External (IURO) Appeal
If your Internal Appeal is not decided in your favor, you (or your provider acting on your behalf with your written consent) can request an External (IURO) Appeal by completing the ***External Appeal Application*** form. A copy of the *External Appeal Application* form will be sent to you with the letter that tells you about the outcome of your Internal Appeal. You or your provider must mail the completed form to the following address within **60 calendar days** of the date on your Internal Appeal outcome letter:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329

You may also **fax** the completed form to 609-633-0807, or send it by **email** to ihcap@dobi.nj.gov.

If a copy of the *External Appeal Application* is not included with your Internal Appeal outcome letter, please call Member Services toll-free at 800-600-4441 (TTY 711) to request a copy.

External (IURO) Appeals are not conducted by Amerigroup Community Care. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either our plan or the State of New Jersey. The IURO will assign your case to an independent physician, who will review your case

and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical condition makes it necessary). You can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or your provider should fax a completed copy of the *External Appeal Application* form to the Department of Banking and Insurance at 609-633-0807, and ask for an expedited appeal on the form in ***Section V, Summary of Appeal***. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about your appeal *within 48 hours*.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance's toll-free telephone number at 888-393-1062 (select option 3).

Please note: There are some services that the IURO will not review. If the letter you receive about the outcome of your appeal does not include information about your option to request an External (IURO) review, this is probably the reason. However, if you have questions about your options, you can call Member Services toll-free at 800-600-4441 (TTY 711).

The External (IURO) Appeal is optional. You don't need to request an External (IURO) appeal before you request a Medicaid State Fair Hearing. Once your Internal Appeal is finished, you have the following options for requesting an External (IURO) Appeal *and/or* a Medicaid State Fair Hearing:

- You can request an External (IURO) Appeal, wait for the IURO's decision, and ***then*** request a Medicaid State Fair Hearing, if the IURO did not decide in your favor.
- You can request an External (IURO) Appeal ***and*** a Medicaid State Fair Hearing ***at the same time*** (just keep in mind that you make these two requests to different government agencies).
- You can request a Medicaid State Fair Hearing *without* requesting an External (IURO) Appeal.

Also, please note: Medicaid Fair Hearings are only available to NJ FamilyCare Plan A and ABP members.

Medicaid State Fair Hearing

You have the option to request a Medicaid State Fair Hearing after your Internal Appeal is finished (and the plan has made a decision). Medicaid State Fair Hearings are administered by staff from the New Jersey Office of Administrative Law. You have up to **120 calendar days** from the date on your ***Internal Appeal outcome letter*** to request a Medicaid State Fair Hearing. But if your appeal is about a pharmacy lock-in determination, you only have 20 calendar days to request a Medicaid State Fair Hearing. You can request a Medicaid State Fair Hearing by writing to the following address:

Fair Hearing Section
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

If you make an expedited (fast) Medicaid State Fair Hearing request, and you meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid Fair Hearing request.

Please note: The deadline for requesting a Medicaid State Fair Hearing is always 120 days from the date on the letter explaining the outcome of your *Internal Appeal*. This is true, even if you request an External (IURO) Appeal in the meantime. The 120-day deadline to ask for a Medicaid State Fair Hearing always starts from the outcome of your *Internal Appeal*, *not* your External (IURO) Appeal. Unless your appeal is about a pharmacy lock-in determination, you only have 20 calendar days to request a Medicaid State Fair Hearing

Continuation of Benefits
If you are asking for an appeal because the plan is stopping or reducing a service or a course of treatment that you have already been receiving, you can have your services/benefits continue during the appeal process. Amerigroup will automatically continue to provide the service(s) while your appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (or your provider, acting on your behalf with your written consent) file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, ***whichever is later***.

Your services will *not* continue automatically during a Medicaid State Fair Hearing. If you want your services to continue during a Medicaid State Fair Hearing, you must request that ***in writing*** when you request a Fair Hearing, and you must make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; ***or*** within
- **10 calendar days** of the date on the letter informing you of the outcome of your External (IURO) Appeal, if you requested one; ***or***
- On or before the final day of the original authorization, ***whichever is later***.

Please note: If you ask to have your services continue during a Medicaid State Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of your continued services.

If you have any questions about the appeal process, you can contact Member Services by calling 800-600-4441 (TTY 711) Monday to Friday from 8 a.m. to 6 p.m. Eastern time.