Policy: **Member Appeals and Grievances – Arkansas**

Date of Implementation: **February 4, 2004**

Product: **Specialty**

American Specialty Health – Specialty (ASH) is committed to promoting effective health care and recognizes that Members have a right to file appeals and grievances. This policy describes the Member appeal and grievance process established by ASH.

The appeals and grievance system has been established with the active participation of key staff and management. The Chief Operations Officer, Clinical Programs (COO), is the designated officer with primary accountability of the appeals and grievances system. The COO is responsible for continuous review of the operation of the appeals and grievances system to identify any emergent patterns. On a quarterly basis, the Quality Oversight Committee (QOC) reviews and approves the Performance Standards that include member appeals and grievances (specified time frames for response and resolution metrics) and reports to the Board of Directors (BOD). The COO reports appeals and grievance information and analysis to the BOD in conjunction with the Chief Health Services Officer (CHSO). The CHSO oversees the appeals and grievance process as it relates to quality of care and reports emergent clinical trends to the COO and BOD. In addition, the CHSO provides corporate review and support to the appeals and grievances policies, processes and trends to ensure there are no processes or systems that are impacting the health care delivery of services provided by ASH or ASH practitioners to members.

Medical necessity review decisions are based solely on the clinical information available to the practitioner at the time that clinical care was provided as communicated to ASH at the time the decision is made. Approval decisions may only be reversed when additional information related to member eligibility and/or benefit information is received and is either materially different from that, which was reasonably available at the time of the original decision, or is a result of fraud, or was submitted erroneously. In the case of a reversal, ASH would continue to provide coverage and make payment for the currently approved ongoing course of treatment while an internal appeal or grievance is under review.

When the resolution of appeals and grievances is not delegated to ASH, ASH will forward the appeal or grievance to the appropriate health plan. ASH will cooperate with the health plan's efforts to resolve the appeal or grievance.

This policy is available to any member, provider, or practitioner upon request. In addition, members are provided, upon request and free of charge, reasonable access to and copies of all documents relevant to an appeal or grievance.

Definitions:

Appeal -

Coverage Dispute/Administrative - Any appeal resulting from an adverse benefit determination unrelated to medical necessity.

Medical Necessity - Any appeal resulting from the adverse benefit determination of treatment/services relative to medical necessity.

Medical Necessity Expedited - An appeal that is resolved expeditiously if the member's health or ability to function could be seriously harmed by waiting for a determination to be made under the normal Medical Necessity Appeal Timeframe, or the practitioner indicates there is an urgent need for continued care.

Site of Care - Any appeal resulting from an adverse Site of Care (SOC) determination where the site of care of the patient is not deemed medically necessary to continue in the Hospital Outpatient Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) department or affiliated clinic and the patient is redirected/transitioned to an in-network non-hospital based PT/OT/SLP clinic setting or virtual setting. These appeals will follow expediated medical necessity appeal processes.

Grievance - A formal expression of dissatisfaction, not involving an ASH decision, that involves quality of care, quality of service, or access to care.

Member - A member or a member's authorized representative, and a provider or practitioner, if the provider or practitioner is acting on behalf of the member and with the member's written consent, collectively referred to as the "Member" throughout this policy.

Pre-Service - An appeal received prior to the provision of care; or after treatment/services have been initiated, but before the ending date of service.

Post-Service - An appeal that involves submission of treatment/services received after the provision of care.

Adverse Benefit Determination – A declination (which includes a denial, reduction, or termination of, or a failure to make partial or whole payment) for a benefit, including any such declination for that plan.

Additionally, with respect to group health plans, a declination for a benefit resulting from the application of any medical necessity review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Deemed Exhaustion of and De Minimis Violations of the Appeals and Grievance Policy

If ASH fails to strictly adhere to all the requirements of its appeals and grievances process, the member is deemed to have exhausted the internal appeals and grievances process, except in the case of a de minimis violation. When the appeals and grievances process is deemed exhausted, a Member is entitled to immediately seek independent review of a claim. (See Section II. entitled Independent Levels of Review.)

In the case of a de minimis violation, ASH may have failed to strictly adhere to all of the requirements of its appeals and grievances process, but this failure:

- Has not caused, nor is it likely to cause, prejudice or harm to a member;
- Was for good cause, or due to matters beyond the control of ASH; and,
- Occurred during the course of an ongoing, good faith exchange of information between ASH and the Member.

ASH cannot claim the de minimis exception if its failure to strictly adhere to its appeals and grievances process is part of a pattern or practice of violations. In these instances, the appeals and grievance process is deemed exhausted and the Member is entitled to seek independent review.

In the event that ASH fails to strictly adhere to its appeals and grievances policy, a Member may request a written explanation of the violation from ASH. ASH must provide such an explanation within 10 days of the Member's request. ASH's response must include a specific description of the basis for asserting that the violation has not caused the internal appeals and grievances process to be deemed exhausted.

If, after a Member has sought independent review of a claim, an independent reviewer or a court rejects the Member's request for immediate review because ASH has met the standards for the de minimis exception, the Member has the right to resubmit an appeal or grievance to ASH. If this occurs, ASH must provide the Member with a notice of the opportunity to resubmit an internal appeal or grievance. ASH must provide this notice within a reasonable time after the independent reviewer or court rejects the Member's

appeal for immediate review, not to exceed 10 days. Time periods for re-filing an appeal or grievance begins at the time of the Member's receipt of such notice.

I. MEMBER APPEALS

Medical Necessity Appeals

Overview

ASH provides a reasonable opportunity to Members for a full and fair review of an adverse benefit determination by offering one (1) level of appeal. An authorized representative (see Member definition above) may act on behalf of a member.

Members are given the opportunity to submit for review written comments, documents, records, and other information relating to their appeal request. This documentation, received in support of the appeal, will be reviewed as part of the appeal, whether or not such documentation was considered at the time of the initial determination. ASH documents if a Member does not submit information related to the appeal within the submission timeframe. If ASH considers or relies on any new or additional evidence in making its determination, ASH will provide that evidence to the member free of charge and as soon as possible, in advance of the determination.

When making an appeal decision of an adverse benefit determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, ASH will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the appeal determination process. In addition, a health care professional engaged in the appeal process for purposes of a consultation will be an individual who was not consulted in connection with the adverse benefit determination or the subordinate of any such individual. Upon request from a Member, ASH will identify the health care professional(s) whose advice was obtained on behalf of ASH in conjunction with the member's adverse benefit determination, without regard to whether the advice was relied upon in making the determination.

During the review of an appeal, the reviewers will not give deference to the initial adverse determination when making their appeal determinations.

ASH continues to provide coverage and make payment for the currently approved ongoing course of treatment while an internal appeal is under review.

Submission Timelines

A Member may submit written or verbal appeals. If a Member disagrees with an initial adverse benefit determination, the Member may file an initial appeal within 180 days from the date the adverse benefit determination letter is mailed.

ASH documents the date when it receives an appeal request, and the date of the decision notification, in ASH's proprietary appeals and grievances database. The request is received upon arrival to ASH, even if it is not first received by the ASH Appeals and Grievance (APG) department.

Notification Acknowledging Receipt of the Appeal

The Member is sent an acknowledgement letter within five (5) calendar days of receiving the appeal. The acknowledgement letter informs the Member that the appeal has been received, the date it was received, the availability of language assistance, and the name, address, and telephone number of the ASH representative handling the appeal. It also includes a statement that at any stage during the appeal process, ASH may, at the request of the member, appoint a staff member to assist the Member with their appeal.

Resolution and Notification Timelines

ASH resolves and notifies the Member, provider and practitioner rendering the service of the determination of a pre-service appeal within 15 calendar days from the receipt of the appeal. ASH resolves and notifies the Member, provider and practitioner rendering the service of the determination of a post-service appeal within 30 calendar days from the receipt of the appeal.

In the case that an appeal decision overturns the initial adverse benefit determination, ASH will implement the decision.

The period of time within which an appeal determination is required to be made begins at the time an appeal is filed with ASH. ASH makes decisions on appeals based on all information provided by the Member within the allowed timeframes, along with all information previously submitted related to the case.

ASH documentation of the appeal includes:

- The member's reason for the appeal of the previous determination
- Action taken, including, but not limited to:
  - Previous adverse determination or appeal history;
  - Follow-up activities associated with the adverse determination and conducted before the current appeal.

Documentation of the appeal is maintained, including the complete investigation of the substance of the appeal and any aspects of clinical care involved. During the review of an

appeal, the reviewers will not give deference to the initial adverse determination when making their appeal determinations.

ASH's response is commensurate with the seriousness and urgency of the appeal. ASH directly responds to the reasons given by the member when appealing and addresses new information provided by the member or practitioner as part of the appeal process.

Reviewers

A clinical director or senior clinician in the same profession and in a same/similar specialty as typically manages the health care service or treatment under review evaluates the appeal and makes a determination. If the clinical director or senior clinician makes a decision in favor of the member, the appeal is considered resolved.

For post-service appeals, if the clinical director or senior clinician makes a decision that is not in favor of the member, the appeal is automatically sent for review by a credentialed practitioner in the same/similar specialty. The appeal decision made by the credentialed practitioner is the final decision at this appeal level.

For pre-service appeals, if the clinical director or senior clinician makes a decision that is not in favor of the member, the appeal is automatically sent for review by an Arkansas-licensed physician (MD/DO). The appeal decision made by the Arkansas-licensed physician (MD/DO) is the final decision at this appeal level.

Medical Doctors or Doctors of Osteopathic Medicine (MD/DO) and clinical quality evaluators are board certified, if applicable, by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. Clinical quality evaluators maintain an active, current, valid and unrestricted license, certificate, or registration in their specialty in a state or territory of the United States. Unless expressly allowed by state or federal laws or regulations, clinical quality evaluators are located in a state or territory of the United States when reviewing an appeal.

For each appeal, the reviewer will attest that the reviewer has the appropriate licensure/certification/registration that typically manages the treatment/services under review and the current experience and knowledge to conduct the appeal review. If the reviewer does not have the requisite licensure, current experience, or knowledge required, they would recuse themselves and inform their manager to reassign the appeal to an appropriate reviewer.

At any stage during the appeal process, ASH may, at the request of the member, appoint a staff member to assist the Member with their appeal.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the Member, provider and practitioner rendering the service. The notification letter includes the following information:

- The unique case identifier (reference number);
- Resolution of the issue;
- List of reviewers' titles (name of reviewers' positions or jobs with the organization), qualifications (clinical credentials, e.g., DC, PT) and the specialty (e.g., chiropractor, physical therapist) of participants in the appeal review;
- Upon request, the name(s) of the reviewer(s);
- A clear and concise explanation in culturally and linguistically appropriate language of reasons for the determination;
- Clinical rationale associated with the decision including the following:
  - The internal rule, guideline, protocol, benefit provision or specific criterion used as it relates to the member's condition relied upon in making the determination; or
- A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the Member, upon request and free of charge, by contacting the Customer Service Department at (800) 678-9133 or on-line at www.ashlink.com;
- A notice regarding the availability of language assistance; and
- Notification that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of documents relevant to the appeal.

Notification of an adverse appeal decision will also include the following:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of ASH to the member's medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation;
- The reason for upholding the appeal decision in language that is specific to the member's condition;
- Language that is easy to understand, so the Member understands why ASH upheld the appeal decision and has enough information to file the next appeal;
- A description of the Member's further appeal rights;
- A statement that Members are not responsible for any charges or fees associated with independent dispute resolution options, unless state law mandates that members pay an IRO filing fee, or the member is in a self-funded plan;
- Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist members with the appeals and independent review processes;

- Information regarding the availability of diagnosis and treatment codes and descriptions; and
- As applicable, additional member health information.

If the outcome of the appeal is adverse to the member, the written notice will include the right of the Member to appeal the decision of the second level review committee to the Commissioner of Insurance or Director, Arkansas insurance Department, Consumer Services, 1 Commerce Way, Suite 102, Little Rock, AR 72202, (501) 371- 2734 or (800) 852-5494; insurance.externalreview@arkansas.gov.

For pre-service appeals, the name, title, address, toll-free telephone number and telephone extension of the Arkansas-licensed physician (MD/DO) responsible for making the adverse determination, along with a listing of each state in which the Arkansas-licensed physician (MD/DO) is licensed and the license number issued by each state.

Independent Levels of Review

If the Member is not satisfied with the determination after the internal levels of appeal are completed, the Member has the option to pursue independent levels of appeal. Additional information regarding the Member's independent levels of review is available in the Independent Levels of Review, Medical Necessity Appeals section of this policy.

Medical Necessity Expedited Appeals

Overview

ASH provides reasonable opportunity to Members for a full and fair review of a pre-service adverse benefit determination by offering an internal level of review for expedited appeals. An authorized representative (see Member definition above) may act on behalf of a member.

Members are given the opportunity to submit for review written comments, documents, records, and other information relating to their appeal request. This documentation, received in support of the appeal, will be reviewed as part of the appeal, whether or not such documentation was considered at the time of the initial determination. ASH documents if a Member does not submit information related to the appeal within the submission timeframe. A post-service appeal is not handled as an expedited appeal and will be handled within the timelines established in the "Medical Necessity Appeals" section of this policy.

When making an appeal decision of an adverse benefit determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, ASH will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the appeal determination process. In addition, a health care professional engaged in the appeal process for purposes of a consultation will be an individual who was not consulted in connection with the adverse benefit determination or the subordinate of any such individual. Upon request from a Member, ASH will identify the health care professional(s) whose advice was obtained on behalf of ASH in conjunction with the member's adverse benefit determination, without regard to whether the advice was relied upon in making the determination.

ASH continues to provide coverage and make payment for the currently approved ongoing course of treatment while an internal appeal is under review.

Submission Timelines

A Member may submit written or verbal appeals within a reasonable timeframe as warranted by the urgency of the member's condition. ASH will initiate an expedited pre-service appeal when requested by the Member or by a practitioner acting on behalf of the member.

ASH documents the date when it receives an appeal request, and the date of the decision notification, in ASH's proprietary appeals and grievances database. The request is received upon arrival to ASH, even if it is not first received by the ASH APG department.

Resolution and Notification Timelines

ASH resolves and notifies the Member verbally of the determination as soon as possible, but no later than 72 hours from the receipt of the appeal. Written confirmation of the verbal notification is provided to the Member, provider and practitioner rendering the service within three (3) calendar days from the receipt of the appeal. The time and date of the notification and the name of the staff member who spoke with the practitioner or Member is recorded.

The period of time within which an appeal determination is required to be made begins at the time an appeal is filed. ASH makes decisions on appeals based on all information provided by the Member with the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the appeal is maintained, including the complete investigation of the substance of the appeal and any aspects of clinical care involved.

Reviewers

A clinical director or senior clinician in the same profession and in a same/similar specialty as typically manages the health care service or treatment under review evaluates the appeal and makes a determination. If the clinical director or senior clinician makes a decision in

favor of the member, the appeal is considered resolved. For post-service appeals, if the clinical director or senior clinician makes a decision that is not in favor of the member, the appeal is automatically sent for review by a credentialed practitioner in the same/similar specialty. The appeal decision made by the credentialed practitioner is the final decision at this appeal level.

For pre-service appeals, if the clinical director or senior clinician makes a decision that is not in favor of the member, the appeal is automatically sent for review by an Arkansas-licensed physician (MD/DO). The appeal decision made by the Arkansas-licensed physician (MD/DO) is the final decision at this appeal level.

Medical Doctors or Doctors of Osteopathic Medicine (MD/DO) and clinical quality evaluators are board certified, if applicable, by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. Clinical quality evaluators maintain an active, current, valid and unrestricted license, certificate, or registration in their specialty in a state or territory of the United States. Unless expressly allowed by state or federal laws or regulations, clinical quality evaluators are located in a state or territory of the United States when reviewing an appeal.

For each appeal, the reviewer will attest that the reviewer has the appropriate licensure/certification/registration that typically manages the treatment/services under review and the current experience and knowledge to conduct the appeal review. If the reviewer does not have the requisite licensure or current experience and/or knowledge required, they would recuse themselves and inform their manager to reassign the appeal to an appropriate reviewer.

At any stage during the appeal process, ASH may, at the request of the member, appoint a staff member to assist the Member with their appeal.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the Member, provider and practitioner rendering the service. The notification letter includes the following information:

- The unique case identifier (reference number);
- Resolution of the issue;
- List of reviewers' titles (name of reviewers' positions or jobs with the organization), qualifications (clinical credentials, e.g., DC, PT) and the specialty (e.g., chiropractor, physical therapist) of participants in the appeal review;
- Upon request, the name(s) of the reviewer(s);
- A clear and concise explanation in culturally and linguistically appropriate language of reasons for the determination;

- Clinical rationale associated with the decision including the following:
  - The internal rule, guideline, protocol, benefit provision or specific criterion used as it related to the member's condition relied upon in making the determination; or
  - A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the Member, upon request and free of charge by contacting the Customer Service Department at (800) 678-9133 or on-line www.ashlink.com;
- A notice regarding the availability of language assistance; and
- Notification that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of documents relevant to the appeal.

Notification of an adverse appeal decision will also include the following:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of ASH to the member's medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation;
- The reason for upholding the appeal decision in language that is specific to the member's condition:
- Language that is easy to understand, so the Member understands why ASH upheld the appeal decision and has enough information to file the next appeal;
- A description of the Member's further appeal rights;
- A statement that Members are not responsible for any charges or fees associated with independent dispute resolution options, unless state law mandates that members pay an IRO filing fee or the member is in a self-funded plan;
- Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist members with the appeals and independent review processes;
- Information regarding the availability of diagnosis and treatment codes and descriptions; and
- As applicable, additional member health information.

Independent Levels of Review

If the Member is not satisfied with the determination after the internal level of appeal is completed, the Member has the option to pursue independent levels of appeal. Additional information regarding the Member's independent levels of review is available in the Independent Levels of Review, Medical Necessity Appeals section of this policy.

II. INDEPENDENT LEVELS OF REVIEW

Medical Necessity Appeals

The member has the right to appeal the decision of the review to the Commissioner of Insurance or Director, Arkansas Insurance Department, Consumer Services, 1 Commerce Way, Suite 102, Little Rock AR 72202, (501) 371-2734 or (800) 852-5464; insurance.externalreview@arkansas.gov.

Overview

ASH provides Members with the opportunity to pursue independent levels of appeal. If the appeal involves a medical necessity adverse benefit determination, the Member may submit a request for an independent level of appeal.

For treatment/services totaling $500 or more, the appeal is reviewed by an Arkansas-approved independent and impartial, accredited Independent Review Organization (IRO). For treatment/services totaling less than $500, the appeal is reviewed by an accredited IRO contracted with ASH. The IRO reviewer shall have no ownership, control or professional, familial or financial conflicts of interest with ASH or the parties involved in the appeal that would influence the outcome of the case. For eligible appeals, ASH will send the contact information for the IRO and the independent review rights and processes to the Member.

For treatment/services totaling $500 or more, when ASH receives a request for an independent review, ASH will submit the request to the IRO within five (5) business days for standard appeals and immediately for expedited appeals.

Throughout the review, the IRO considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decision or conclusions of the internal appeal. ASH does not attempt to interfere with the IRO's proceedings or appeal decision.

The Member is not responsible for any charges or fees associated with independent dispute resolution options unless state law mandates that members pay an IRO filing fee or the member is in a self-funded plan.

The independent review decision is binding on ASH and the member except to the extent that other remedies are available under state and federal law. Binding decisions will not stop ASH from making payments on claims or providing benefits at any time, including after a final independent review decision that denies the claim or otherwise fails to require such payment or benefits. ASH must provide benefits pursuant to the final independent review decision without delay, regardless of whether ASH intends to seek judicial review of the independent review decision.

ASH maintains or obtains data from the IRO on each appeal case and uses this information in evaluating the medical necessity decision-making process.

Submission Timelines

For treatment/services totaling less than $500, a Member may submit a written or verbal request for an independent review to ASH. If a Member disagrees with an appeal decision, the Member may file a request for an independent level of review within 120 days (four (4) months) of the date of the adverse appeal determination letter. After receipt of the appeal by the IRO, the member has at least five (5) business days to submit to the IRO in writing additional information that the IRO must consider when conducting the independent review.

For treatment/services totaling $500 or more, a Member may submit a written or electronic request for an external review to ASH. If a Member disagrees with an appeal decision, he/she may file a request for a voluntary level of review within sixty (60) calendar days of the date of the adverse appeal determination letter.

Resolution and Notification Timelines

ASH ensures the appeal is resolved and notifies the Member of the IRO determination of an appeal within 45 calendar days from the receipt of the appeal. For cases involving urgent care, ASH ensures the appeal is resolved and notifies the Member of the IRO determination within 72 hours from the date the Member initiates the independent review.

Notification of the IRO Decision

ASH will send notification of the review determination based on submitted information from the contracted IRO.

The notification letter includes the following information:

- The unique case identifier (reference number);
- Resolution of the issue;
- List of titles and qualifications of participants in the appeal review;
- Notification that the Member is entitled to receive, upon request, reasonable access to and copies of documents relevant to the appeal; and
- The timeframe specified by the IRO within which ASH will implement the IRO decision.

Notification of an adverse appeal decision will also include the following:

- A clear and concise explanation in culturally and linguistically appropriate language of reasons for the determination;
- A description of the Member's further appeal rights which includes arbitration and civil action, if applicable.

Right to Arbitration
If the Member is not satisfied with the determination of the appeal after the IRO review, the Member may initiate an independent level of appeal consisting of arbitration through the American Arbitration Association (the Association) . To obtain more information about the Association call the Association at (877) 495-4185. The Association's arbitration determination will be binding.

Right to Civil Action
The Member may have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act if all levels of review of the appeal have been completed and the appeal has not been approved.

III. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS

Overview
ASH will provide a reasonable opportunity to Members for a full and fair review of an adverse benefit determination by offering two (2) levels of appeal. Members are given the opportunity to submit for review written comments, documents, records, and other information relating to their appeal request. This documentation, received in support of the appeal, will be reviewed as part of the appeal, whether or not such documentation was considered at the time of the initial determination.

Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the appeal determination process.

Submission Timelines
A Member may submit written or verbal appeals. If a Member disagrees with an initial adverse benefit determination, the Member may file an initial appeal within 180 days from the date the adverse benefit determination letter is mailed.

Notification Acknowledging Receipt of the Appeal
The Member is sent an acknowledgement letter within five (5) calendar days of receiving the appeal. The acknowledgement letter informs the Member that the appeal has been received, the date it was received, the availability of language assistance, and the name, address, and telephone number of the ASH representative handling the appeal. It also includes a statement that at any stage in the appeal process, ASH may, at the request of the member, appoint a staff member to assist the Member with their appeal.

Resolution and Notification Timelines
ASH resolves and notifies the Member of the determination at each level of a pre-service appeal within 15 calendar days from the receipt of the appeal. ASH resolves and notifies

the Member of the determination at each level of a post-service appeal within 30 calendar days from the receipt of the appeal.

The period of time within which an appeal determination is required to be made begins at the time an appeal is filed. ASH makes decisions on appeals based on all information provided by the Member within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the appeal is maintained, including the complete investigation of the substance of the appeal and any aspects of clinical care involved.

Reviewers

1st Level: A minimum of two (2) operational managers will review the appeal and make a determination.

2nd Level: The Administrative Review Committee (ARC) will review the appeal and make the final determination at this level.

At any stage of the appeal process, ASH may, at the request of the member, appoint a staff member to assist the Member with their appeal.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the Member. The notification letter includes the following information:

- The unique case identifier (reference number);
- Resolution of the issue;
- List of titles, qualifications and the specialty of participants in the appeal review;
- Upon request, the name(s) of the reviewer(s);
- A notice regarding the availability of language assistance; and
- Notification that the member is entitled to receive, upon request, reasonable access to and copies of documents relevant to the appeal.

Notification of an adverse appeal decision will also include the following:

- A clear and concise explanation in culturally and linguistically appropriate language of reasons for the determination;
- Rationale associated with the decision including the following:
  - The internal rule, guideline, protocol, benefit provision or other similar criterion relied upon in making the determination; or
  - A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the Member, upon request and free of charge by contacting the Customer Service Department at (800) 678-9133 or on-line at www.ashlink.com.

- A description of the Member's further appeal rights including notification that the Member is given 45 calendar days to submit to the next level of appeal.

Voluntary Levels of Review

If the Member is not satisfied with the determination after review by the ARC, the Member has the option to pursue voluntary levels of appeal. Additional information regarding the member's voluntary levels of review is available in the Voluntary Levels of Review, Coverage Disputes/Administrative Appeals section of this policy.

IV. VOLUNTARY LEVELS OF REVIEW

Coverage Disputes/Administrative Appeals

Overview

ASH provides Members with the option to pursue voluntary levels of appeal. If the appeal involves a benefit coverage limitation, other than medical necessity, the Member may submit a request for a voluntary level of appeal. The Member is not responsible for any charges or fees associated with voluntary dispute resolution options.

Submission Timelines

A Member may submit a written or verbal request for a voluntary level of review. If a Member disagrees with an appeal decision, the Member may contact ASH within forty-five (45) calendar days of the date of the adverse benefit determination letter.

Resolution and Notification Timelines

ASH resolves and notifies the Member of the determination within thirty (30) calendar days of receipt of the appeal request.

Reviewers

The voluntary level of review will be conducted by ASH's Executive Review Committee (ERC). This committee consists of the COO, Senior Vice President, Operations, and a credentialed practitioner.

Notification of the ERC Decision

After a decision is made regarding the appeal, a resolution letter is sent to the Member. The notification letter includes the following information:

- The unique case identifier (reference number);
- Resolution of the issue, which includes timeframes and procedures for a claim payment or approval of treatment/services in the event ERC overturns the decision;
- List of titles and qualifications of participants in the appeal review.

Notification of an adverse appeal decision will also include the following:

- A clear and concise explanation in culturally and linguistically appropriate language of reasons for the determination;
- Rationale associated with the decision including the following:
  - The internal rule, guideline, protocol, benefit provision or other similar criterion relied upon in making the determination; or
  - A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the Member, upon request and free of charge.
- A description of the Member's further appeal rights, including arbitration and civil action.

Right to Arbitration

If the Member is not satisfied with the determination of the appeal after the ERC review, the Member may initiate a voluntary level of appeal consisting of arbitration through the American Arbitration Association (the Association). To obtain more information about the Association call the Association at (877) 495-4185. The Association's arbitration determination will be binding.

Right to Civil Action

The Member may have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act if all levels of review of the appeal have been completed and the appeal has not been approved.

V. MEMBER GRIEVANCES

Quality of Care Grievances

Overview

ASH provides Members with an opportunity to submit a grievance regarding dissatisfaction of the quality of care received. ASH offers one (1) grievance level. Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the grievance determination process. A health care professional engaged in the grievance process for purposes of a consultation must be an individual who was not consulted in connection with the grievance or the subordinate of any such individual.

The grievance reviewers consider any previous quality of care grievances against the provider or practitioner.

Submission Timeline
A Member may submit written or verbal grievances. If a Member is dissatisfied with the quality of care received, the Member may file a grievance within 180 days of the incident.

Notification Acknowledging Receipt of the Grievance
The Member is sent an acknowledgement letter within five (5) calendar days of receiving the grievance. The acknowledgement letter informs the Member that the grievance has been received, the date it was received, the availability of language assistance, and the name, address, and telephone number of the ASH representative handling the grievance.

Resolution Timeline
Grievances are resolved within 30 calendar days from the receipt of the grievance.

Reviewers
A senior clinical quality evaluator investigates the grievance and makes a determination. After the grievance is investigated by a senior clinical quality evaluator, the grievance is sent for review by the ASH Practice Review Committee (PRC). The grievance decision made by PRC is the final decision at this grievance level.

Notification of Grievance Resolution
After a determination is made regarding the grievance, a resolution letter is sent to the Member within 30 calendar days from the receipt of the grievance. The notification letter includes the following information:

- The unique case identifier (reference number);
- Final resolution of the issue;
- A clear and concise explanation of reasons for the determination;
- A description of clinical criteria used, and the clinical rationale associated with the decision;
- A notice regarding the availability of language assistance; and
- A statement that Members retain the right to pursue all grievance and complaint mechanisms available through the applicable state or Federal regulatory agencies or as otherwise provided under law.

Quality of Service and Access to Care Grievances

Overview
ASH provides Members with an opportunity to submit a grievance regarding dissatisfaction of the quality of service received and/or access to care. ASH offers one (1) grievance level. Individuals who were not involved in any previous decisions and who are not subordinates of any such individual participate in the grievance determination process.

A qualified individual will investigate the Member's issue.

Submission Timeline
A Member may submit written or verbal grievances. If a Member is dissatisfied with the quality of service or access to care, the Member may file a grievance within 180 days of the incident.

Notification Acknowledging Receipt of the Grievance
The Member is sent an acknowledgement letter within five (5) calendar days of receiving the grievance. The acknowledgement letter informs the Member that the grievance has been received, the date it was received, the availability of language assistance, and the name, address, and telephone number of the ASH representative handling the grievance.

Resolution Timeline
Grievances are resolved within 30 calendar days from the receipt of the grievance.

Reviewers
The APG department reviews the grievance and makes a final determination to resolve the issue.

Notification of Grievance Resolution
After a determination is made regarding the grievance, a resolution letter is sent to the Member within 30 calendar days from the receipt of the grievance. The notification letter includes the following information:

- The unique case identifier (reference number);
- Final resolution of the issue;
- A clear and concise explanation of reasons for the determination;
- A description of criteria used, and the rationale associated with the decision;
- A notice regarding the availability of language assistance; and
- A statement that Members retain the right to pursue all grievance and complaint mechanisms available through the applicable state and Federal regulatory agencies or as otherwise provided under law.

VI. RECORD KEEPING

ASH maintains records for each appeal and grievance that includes the following:

- The name of the member, provider and/or practitioner rendering service;
- Copies of all correspondence from the Member, provider and practitioner rendering service and ASH regarding the appeal and grievance;
- Dates of appeal and grievance reviews,
- Documentation of actions taken, including previous adverse determination and/or appeal history and follow up activities associated with adverse determinations and conducted before the current appeal,
- Final resolution; and

- The name and credentials of the peer clinical quality evaluator that reviewed the appeal, if applicable.

Applicable meeting minutes are reviewed, signed by the chairperson, and maintained as the official meeting record.