

1 **Policy:** **Provider and Practitioner Appeals and Grievances –**
2 **Arkansas**

3
4 **Date of Implementation:** **November 19, 2015**

5
6 **Product:** **Specialty**
7

8
9 American Specialty Health – Specialty (ASH) is committed to promoting effective health
10 care and recognizes that providers and practitioners have a right to file appeals and
11 grievances. This policy describes the provider and practitioner appeal and grievance
12 processes established by ASH.

13
14 When the resolution of appeals is not delegated to ASH, ASH will forward the appeal to
15 the appropriate health plan. ASH will cooperate with the health plan’s efforts to resolve
16 the appeal.

17
18 **Definitions:**

19 ***Appeal -***

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

22
23 ***Medical Necessity*** - Any appeal resulting from the adverse benefit determination
24 of treatment/services relative to medical necessity.

25
26 ***Medical Necessity Expedited*** - An appeal that is resolved expeditiously if the
27 member’s health or ability to function could be seriously harmed by waiting
28 for a determination to be made under the normal Medical Necessity Appeal
29 Timeframe, or the practitioner indicates there is an urgent need for
30 continued care.

31
32 ***Site of Care*** - Any appeal resulting from an adverse Site of Care (SOC)
33 determination where the site of care of the patient is not deemed medically
34 necessary to continue in the Hospital Outpatient Physical Therapy (PT),
35 Occupational Therapy (OT), and Speech Language Pathology (SLP)
36 department or affiliated clinic and the patient is redirected/transitioned to
37 an in-network non-hospital based PT/OT/SLP clinic setting or virtual
38 setting. These appeals will follow expediated medical necessity appeal
39 processes.

40
41 ***Grievance*** - A formal expression of dissatisfaction not involving an ASH decision that
42 involves quality of care, quality of service, or access to care.

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

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

9
10 If a provider or practitioner files an appeal on behalf of a member with the member’s
11 written consent, the appeal process defined in the *ASH Member Appeals and Grievances*
12 – *Arkansas (AR UM 4 – S)* policy will be followed.

13
14 **Effect of Filing an Appeal or Grievance**

15 ASH will take no retaliatory actions against the provider or practitioner as a result of filing
16 an appeal or grievance.

17
18 **I. PROVIDER AND PRACTITIONER APPEALS**

19
20 **Medical Necessity Appeals**

21 **Overview**

22 ASH provides reasonable opportunity to providers and practitioners for a full and fair
23 review of an adverse benefit determination by offering one (1) level of appeal.

24
25 At each level of appeal, providers and practitioners are given the opportunity to submit for
26 review written comments, documents, records, and other information relating to their
27 appeal request. This documentation, received by ASH in support of the appeal, is reviewed
28 as a component of the appeal, whether or not such documentation was considered at the
29 time of the initial determination. ASH documents if a practitioner does not submit
30 information related to the appeal within the submission timeframe.

31
32 When making an appeal decision of an adverse benefit determination with regard to
33 whether a particular treatment, drug, or other item is experimental, investigational, or not
34 medically necessary or appropriate, ASH will consult with a health care professional that
35 has appropriate training and experience in the field of medicine involved in the medical
36 judgment.

37
38 Individuals who were not involved in any previous decisions and who are not subordinates
39 of any such individual participate in the appeal determination process. In addition, a health
40 care professional engaged in the appeal process for purposes of a consultation will be an
41 individual who was not consulted in connection with the adverse benefit determination or
42 the subordinate of any such individual.

1 If a provider or practitioner submits an appeal for services the member has already
 2 appealed, the provider or practitioner request will be dismissed and the member request
 3 will be processed. If the provider or practitioner has appealed, the member can still appeal
 4 but not vice versa, unless a provider or practitioner provides significant additional
 5 information supporting the medical necessity that was not available at the time of the
 6 member's appeal.

7
 8 During the review of an appeal, the reviewers will not give deference to the initial adverse
 9 determination when making their appeal determinations.

10
 11 ASH continues to provide coverage and make payment for the currently approved ongoing
 12 course of treatment while an internal appeal is under review.

13 14 **Submission Timelines**

15 If a provider or practitioner disagrees with an initial adverse benefit determination, the
 16 provider or practitioner may appeal within 180 days of the date of the adverse benefit
 17 determination notification letter. Appeals may be submitted in writing, verbally, or on-line
 18 at www.ashlink.com.

19 20 **Resolution and Notification Timelines**

21 ASH resolves and notifies the provider or practitioner of a pre-service appeal within 15
 22 calendar days from the receipt of the appeal. ASH resolves and notifies the provider or
 23 practitioner of a post-service appeal within 30 calendar days from the receipt of the appeal.

24
 25 In the case that an appeal decision overturns the initial adverse benefit determination, ASH
 26 will implement the decision.

27
 28 The period of time within which an appeal determination is required to be made begins at
 29 the time an appeal is filed with ASH. ASH makes decisions on appeals based on all
 30 information provided by the provider or practitioner within the allowed timeframes, along
 31 with all information previously submitted related to the case.

32
 33 Documentation of the provider or practitioner appeal is maintained, including the complete
 34 investigation of the substance of the appeal and any aspects of clinical care involved.

35 36 **Reviewers**

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

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

5
 6 For pre-service appeals, if the clinical director or senior clinician makes a decision that is
 7 not in favor of the member, the appeal is automatically sent for review by an Arkansas-
 8 licensed physician (MD/DO). The appeal decision made by the Arkansas-licensed
 9 physician (MD/DO) is the final decision at this appeal level.

10
 11 Medical Doctors or Doctors of Osteopathic Medicine (MD/DO) and clinical quality
 12 evaluators are board certified, if applicable, by a specialty board approved by the American
 13 Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. Clinical
 14 quality evaluators maintain an active, current, and unrestricted license, certificate, or
 15 registration in their specialty in a state or territory of the United States. Unless expressly
 16 allowed by state or federal laws or regulations, clinical quality evaluators are located in a
 17 state or territory of the United States when reviewing an appeal.

18
 19 For each appeal, the reviewer will attest that he/she has the appropriate
 20 licensure/certification/registration that typically manages the treatment/services under
 21 review and the experience and knowledge to conduct the appeal review.

22 23 **Notification of Appeal Resolution**

24 After a decision is made regarding the appeal, a resolution letter is sent to the provider or
 25 practitioner. The notification letter includes the following information:

- 26 • Resolution of the issue;
- 27 • List of titles, qualifications and the specialty of participants in the appeal review;
- 28 • A clear and concise explanation in culturally and linguistically appropriate
 29 language of reasons for determination;
- 30 • Clinical rationale associated with the decision including the following:
 - 31 ○ The internal rule guideline, protocol, benefit provision or other similar criterion
 32 relied upon in making the determination; or
 - 33 ○ A statement that such rule, guideline, protocol, benefit provision, or other
 34 similar criterion was relied upon in making the determination and a statement
 35 that a copy of such will be provided to the practitioner, upon request and free
 36 of charge by contacting the Customer Service Department at (800) 972-4226 or
 37 on-line at www.ashlink.com; and
- 38 • Notification that the provider or practitioner is entitled to receive, upon request and
 39 free of charge, reasonable access to and copies of documents relevant to the appeal.

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

- 2 • An explanation of the scientific or clinical judgment for the determination, applying
- 3 the terms of ASH to the medical circumstances if the adverse benefit determination
- 4 is based on the medical necessity or experimental treatment or similar exclusion or
- 5 limitation.
- 6 • A description of the provider or practitioner’s further appeal rights including
- 7 notification that the provider or practitioner is given 45 calendar days to submit to
- 8 the next level of appeal, if applicable.

10 **Independent Levels of Review**

11 If the provider or practitioner is not satisfied with the determination after the internal levels
 12 of appeal are completed, the provider or practitioner has the option to pursue an
 13 independent level of appeal. Additional information regarding the practitioner’s
 14 independent levels of review is available in the Independent Levels of Review, Medical
 15 Necessity Appeals section of this policy.

17 **Medical Necessity Expedited Appeals**

18 **Overview**

19 ASH provides reasonable opportunity to providers and practitioners for a full and fair
 20 review of a pre-service adverse benefit determination by offering an internal level of review
 21 for expedited appeals.

22
 23 Providers and practitioners are given the opportunity to submit written comments,
 24 documents, records, and other information relating to their appeal request. This
 25 documentation, received in support of the appeal, will be reviewed as part of the appeal,
 26 whether or not such documentation was considered at the time of the initial determination.
 27 ASH documents if a practitioner does not submit information related to the appeal within
 28 the submission timeframe. A post-service appeal is not handled as an expedited appeal and
 29 will be handled within the timelines established in the Provider and Practitioner Medical
 30 Necessity Appeals section of this policy.

31
 32 When making an appeal decision of an adverse benefit determination with regard to
 33 whether a particular treatment, drug, or other item is experimental, investigational, or not
 34 medically necessary or appropriate, ASH will consult with a healthcare professional that
 35 has appropriate training and experience in the field of medicine involved in the medical
 36 judgment.

37
 38 Individuals who were not involved in any previous decisions and who are not subordinates
 39 of any such individual participate in the appeal determination process. In addition, a health
 40 care professional engaged in the appeal process for purposes of a consultation will be an
 41 individual who was not consulted in connection with the adverse benefit determination or
 42 the subordinate of any such individual.

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

3
4 ASH continues to provide coverage and make payment for the currently approved ongoing
5 course of treatment while an internal appeal is under review.

6
7 **Submission Timelines**

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

11
12 **Resolution and Notification Timelines**

13 ASH resolves and notifies the provider or practitioner verbally of the determination as soon
14 as possible, but no later than 72 hours from the receipt of the appeal. Written confirmation
15 of the notification is provided to the provider or practitioner within three (3) calendar days
16 from the receipt of the appeal.

17
18 The period of time within which an appeal determination is required to be made begins at
19 the time an appeal is filed. ASH makes decisions on appeals based on all information
20 provided by the provider or practitioner within the allowed timeframes, along with all
21 information previously submitted related to the case.

22
23 Documentation of the provider or practitioner appeal is maintained, including the complete
24 investigation of the substance of the appeal and any aspects of clinical care involved.

25
26 **Reviewers**

27 A clinical director or senior clinician in the same/similar specialty reviews the appeal. If
28 the clinical director or senior clinician makes a decision in favor of the provider or
29 practitioner, the appeal is considered resolved.

30
31 For post-service appeals, if the clinical director or senior clinician makes a decision that is
32 not in favor of the member, the appeal is automatically sent for review by a credentialed
33 practitioner in the same/similar specialty. The appeal decision made by the credentialed
34 practitioner is the final decision at this appeal level.

35
36 For pre-service appeals, if the clinical director or senior clinician makes a decision that is
37 not in favor of the member, the appeal is automatically sent for review by an Arkansas-
38 licensed physician (MD/DO). The appeal decision made by the Arkansas-

39
40 Medical Doctors or Doctors of Osteopathic Medicine (MD/DO) and clinical quality
41 evaluators are board certified, if applicable, by a specialty board approved by the American
42 Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. Clinical

1 quality evaluators maintain an active, current, and unrestricted license, certificate, or
 2 registration in their specialty in a state or territory of the United States. Unless expressly
 3 allowed by state or federal laws or regulations, clinical quality evaluators are located in a
 4 state or territory of the United States when reviewing an appeal.

5
 6 For each appeal, the reviewer will attest that he/she has the appropriate
 7 licensure/certification/registration that typically manages the treatment/services under
 8 review and the experience and knowledge to conduct the appeal review.

10 **Notification of Appeal Resolution**

11 After a decision is made regarding the appeal, a resolution letter is sent to the provider or
 12 practitioner. The notification letter includes the following information:

- 13 • Resolution of the issue;
- 14 • List of titles, qualifications and the specialty of participants in the appeal review;
- 15 • A clear and concise explanation in culturally and linguistically appropriate
 16 language of reasons for determination;
- 17 • Clinical rationale associated with the decision including the following:
 - 18 ○ The internal rule guideline, protocol, benefit provision or other similar criterion
 19 relied upon in making the determination; or
 - 20 ○ A statement that such rule, guideline, protocol, benefit provision, or other
 21 similar criterion was relied upon in making the determination and a statement
 22 that a copy of such will be provided to the practitioner, upon request and free
 23 of charge by contacting the Customer Service Department at (800) 972-4226 or
 24 on-line at www.ashlink.com; and
- 25 • Notification that the provider or practitioner is entitled to receive, upon request and
 26 free of charge, reasonable access to and copies of documents relevant to the appeal.

27
 28 Notification of an adverse appeal decision will also include the following:

- 29 • An explanation of the scientific or clinical judgment for the determination, applying
 30 the terms of ASH to the medical circumstances if the adverse benefit determination
 31 is based on the medical necessity or experimental treatment or similar exclusion or
 32 limitation; and
- 33 • A description of the practitioner's further appeal rights.

34
 35 For pre-service appeals, the name, title, address, toll-free telephone number and telephone
 36 extension of the Arkansas licensed physician (MD/DO) responsible for making the adverse
 37 determination, along with a listing of each state in which the Arkansas-licensed physician
 38 (MD/DO) is licensed and the license number issued by each state.

40 **Independent Levels of Review**

41 If the provider or practitioner is not satisfied with the determination after the internal level
 42 of appeal is completed, the provider or practitioner has the option to pursue an independent

1 level of appeal. Additional information regarding the practitioner’s independent levels of
2 review is available in the Independent Levels of Review, Medical Necessity Appeals
3 section of this policy.

4
5 **II. INDEPENDENT LEVELS OF REVIEW**

6
7 **Medical Necessity Appeals**

8 **Overview**

9 ASH provides providers and practitioners with the option to pursue **one (1)** voluntary level
10 of appeal, either independent review or arbitration.

11
12 **Independent Review Process**

13 The provider or practitioner may request an independent review by contacting ASH. If the
14 provider or practitioner chooses to pursue a review through an Independent Review
15 Organization (IRO), there is a \$50 charge and the decision of the IRO is binding.

16
17 **Arbitration**

18 The provider or practitioner may initiate arbitration through the American Arbitration
19 Association (the Association). To initiate the arbitration process, the practitioner may
20 contact the Association at (877) 495-4185. The Association arbitration determination is
21 binding.

22
23 **III. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS**

24
25 **Overview**

26 ASH provides reasonable opportunity to providers or practitioners for a full and fair review
27 of an adverse benefit determination by offering three (3) levels of appeal. At each level of
28 appeal, provider or practitioners are given the opportunity to submit for review written
29 comments, documents, records, and other information relating to their appeal request. This
30 documentation, received by ASH in support of the appeal, is reviewed as a component of
31 the appeal, whether or not such documentation was considered at the time of the initial
32 determination.

33
34 Individuals who were not involved in any previous decisions and who are not subordinates
35 of any such individual participate in the appeal determination process.

36
37 **Submission Timelines**

38 If a provider or practitioner disagrees with an initial adverse determination, he/she may
39 appeal within 180 days of the date of the adverse benefit determination notification letter.
40 Appeals may be submitted in writing, verbally, or on-line at www.ashlink.com.

1 **Resolution and Notification Timelines**

2 ASH resolves and notifies the provider or practitioner of each level of an administrative
3 appeal within 30 calendar days from the receipt of the appeal.

4
5 The period of time within which an appeal determination is required to be made begins at
6 the time an appeal is filed with ASH. ASH makes decisions on appeals based on all
7 information provided by the provider or practitioner within the allowed timeframes, along
8 with all information previously submitted related to the case.

9
10 Documentation of the provider or practitioner appeal is maintained, including the complete
11 investigation of the substance of the appeal and any aspects of clinical care involved.

12 **Reviewers**

13
14 1st Level: A minimum of two (2) operational managers reviews the appeal and makes an
15 appeal determination.

16 2nd Level: The Administrative Review Committee (ARC) reviews the appeal and makes
17 an appeal determination.

18 3rd Level: The Executive Review Committee (ERC) reviews the appeal and makes an
19 appeal determination. The appeal decision made by the ERC is the final decision at this
20 appeal level.

21 **Notification of Appeal Resolution**

22
23 After a decision is made regarding the appeal, a resolution letter is sent to the provider or
24 practitioner. The notification letter includes the following information:

- 25 • Resolution of the issue;
- 26 • List of titles, qualifications and the specialty of participants in the appeal review;
- 27 and
- 28 • Notification that the provider or practitioner is entitled to receive, upon request,
29 reasonable access to and copies of documents relevant to the appeal.

30
31 Notification of an adverse appeal decision will also include the following:

- 32 • A clear and concise explanation in easily understandable language of reasons for
33 the determination;
- 34 • Rationale associated with the decision including the following:
 - 35 ○ The internal rule guideline, protocol, benefit provision or other similar criterion
36 relied upon in making the determination; or
- 37 • A description of the provider or practitioner’s further appeal rights which includes
38 arbitration, if applicable.

39 **Arbitration**

40
41 The provider or practitioner may initiate arbitration through the American Arbitration
42 Association (the Association). To initiate the arbitration process, the provider or

1 practitioner may contact the Association at (877) 495-4185. The Association arbitration
2 determination is binding.

3 4 **IV. PROVIDER AND PRACTITIONER GRIEVANCES**

5 6 **Overview**

7 ASH provides providers and practitioners with the opportunity to submit a grievance if
8 they are dissatisfied with ASH policies, procedures, or service. ASH offers one (1)
9 grievance level.

10 11 **Submission Timeline**

12 A provider or practitioner may submit a formal verbal or written grievance to ASH at any
13 time.

14 15 **Resolution Timeline**

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

17 18 **Reviewers**

19 The Appeals and Grievances (APG) department researches and reviews the case, and if
20 applicable, contacts the provider or practitioner in an effort to resolve the grievance.

21 22 **Notification of Grievance Resolution**

23 After a determination is made regarding the grievance, a resolution letter is sent to the
24 provider or practitioner. The notification letter includes the following information:

- 25 • A summary of the grievance;
- 26 • Resolution of each issue, including a clear and concise explanation of reasons for
27 determination; and
- 28 • Notification that the provider or practitioner may have a right to file their grievance
29 in accordance with their state’s grievance procedures, if available.