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

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

Product: **Specialty**

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

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

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.

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.

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

Effect of Filing an Appeal or Grievance
ASH will take no retaliatory actions against the provider or practitioner as a result of filing an appeal or grievance.

I. PROVIDER AND PRACTITIONER APPEALS

Medical Necessity Appeals

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

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

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 that 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.

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

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

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

Resolution and Notification Timelines

ASH resolves and notifies the provider or practitioner of a pre-service appeal within 15 calendar days from the receipt of the appeal. ASH resolves and notifies the provider or practitioner of a post-service 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 provider or practitioner within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the provider or practitioner 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 he/she has the appropriate licensure/certification/registration that typically manages the treatment/services under review and the experience and knowledge to conduct the appeal review.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the provider or practitioner. 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;
- A clear and concise explanation in culturally and linguistically appropriate language of reasons for determination;
- Clinical 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 practitioner, upon request and free of charge by contacting the Customer Service Department at (800) 972-4226 or on-line at www.ashlink.com; and
- Notification that the provider or practitioner 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 medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation.
- A description of the provider or practitioner's further appeal rights including notification that the provider or practitioner is given 45 calendar days to submit to the next level of appeal, if applicable.

Independent Levels of Review

If the provider or practitioner is not satisfied with the determination after the internal levels of appeal are completed, the provider or practitioner has the option to pursue an independent level of appeal. Additional information regarding the practitioner'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 providers and practitioners for a full and fair review of a pre-service adverse benefit determination by offering an internal level of review for expedited appeals.

Providers and practitioners are given the opportunity to submit 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 practitioner 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 Provider and Practitioner 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 healthcare professional that 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.

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 provider or practitioner 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 provider or practitioner.

Resolution and Notification Timelines

ASH resolves and notifies the provider or practitioner verbally of the determination as soon as possible, but no later than 72 hours from the receipt of the appeal. Written confirmation of the notification is provided to the provider or practitioner within three (3) 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 provider or practitioner within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the provider or practitioner 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/similar specialty reviews the appeal. If the clinical director or senior clinician makes a decision in favor of the provider or practitioner, 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.

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 he/she has the appropriate licensure/certification/registration that typically manages the treatment/services under review and the experience and knowledge to conduct the appeal review.

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the provider or practitioner. 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;
- A clear and concise explanation in culturally and linguistically appropriate language of reasons for determination;
- Clinical 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 practitioner, upon request and free of charge by contacting the Customer Service Department at (800) 972-4226 or on-line at www.ashlink.com; and
- Notification that the provider or practitioner 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 medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation; and
- A description of the practitioner's further appeal rights.

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 provider or practitioner is not satisfied with the determination after the internal level of appeal is completed, the provider or practitioner has the option to pursue an independent level of appeal. Additional information regarding the practitioner'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

Overview

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

Independent Review Process

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

Arbitration

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

III. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS

Overview

ASH provides reasonable opportunity to providers or practitioners for a full and fair review of an adverse benefit determination by offering three (3) levels of appeal. At each level of appeal, provider or practitioners are given the opportunity to submit for review written comments, documents, records, and other information relating to their appeal request. This documentation, received by ASH in support of the appeal, is reviewed as a component 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

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

Resolution and Notification Timelines

ASH resolves and notifies the provider or practitioner of each level of an administrative 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 with ASH. ASH makes decisions on appeals based on all information provided by the provider or practitioner within the allowed timeframes, along with all information previously submitted related to the case.

Documentation of the provider or practitioner 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 reviews the appeal and makes an appeal determination.

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

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

Notification of Appeal Resolution

After a decision is made regarding the appeal, a resolution letter is sent to the provider or practitioner. 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; and
- Notification that the provider or practitioner 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 easily understandable 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 description of the provider or practitioner's further appeal rights which includes arbitration, if applicable.

Arbitration

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

IV. PROVIDER AND PRACTITIONER GRIEVANCES

Overview

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

Submission Timeline

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

Resolution Timeline

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

Reviewers

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

Notification of Grievance Resolution

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

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