

1 **Policy:** **Member Appeals and Grievances – New Jersey**

2

3 **Date of Implementation:** **July 14, 2005**

4

5 **Product:** **Specialty**

6

7

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

11

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

26

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

36

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

40

41 The member has the right to appoint a representative to act on his/her behalf. The Customer  
 42 Service and Appeals Departments have forms available, which the member may use to

1 appoint a representative. When the form has been completed and returned, the name of the  
 2 representative will be added to ASH’s files. A representative may be designated at any  
 3 point in the appeal process.

4  
 5 This policy is available to any member, provider, or practitioner upon request. In addition,  
 6 members are provided, upon request and free of charge, reasonable access to and copies of  
 7 all documents relevant to an appeal or grievance.

8  
 9 **Definitions:**

10 ***Appeal -***

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

13  
 14 ***Medical Necessity*** - Any appeal resulting from the adverse benefit determination  
 15 of treatment/services relative to medical necessity.

16  
 17 ***Medical Necessity Expedited*** - An appeal that is resolved expeditiously if the  
 18 member’s health or ability to function could be seriously harmed by waiting  
 19 for a determination to be made under the normal Medical Necessity Appeal  
 20 Timeframe, or the practitioner indicates there is an urgent need for  
 21 continued care.

22  
 23 ***Site of Care*** - Any appeal resulting from an adverse Site of Care (SOC)  
 24 determination where the site of care of the patient is not deemed medically  
 25 necessary to continue in the Hospital Outpatient Physical Therapy (PT),  
 26 Occupational Therapy (OT), and Speech Language Pathology (SLP)  
 27 department or affiliated clinic and the patient is redirected/transitioned to  
 28 an in-network non-hospital based PT/OT/SLP clinic setting or virtual  
 29 setting. These appeals will follow expediated medical necessity appeal  
 30 processes.

31  
 32 ***Grievance*** - A formal expression of dissatisfaction, not involving an ASH decision, that  
 33 includes but is not limited to quality of care, quality of service, or access to  
 34 care.

35  
 36 ***Member*** - A member or a member’s authorized representative, and a provider or  
 37 practitioner, if the provider or practitioner is acting on behalf of the member  
 38 and with the member’s written consent, collectively referred to as the  
 39 “Member” throughout this policy.

40  
 41 ***Pre-Service*** - An appeal received prior to the provision of care; or after treatment/services  
 42 have been initiated, but before the ending date of service.

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

3  
 4 **Same/Similar** – A clinical quality evaluator would be considered to be a same/similar  
 5 practitioner if he/she is credentialed, state licensed, certified, or registered to  
 6 provide clinical services equivalent to the services rendered by the treating  
 7 practitioner  
 8

9 **Urgent Services** – For contracted practitioners/providers, urgent services are covered  
 10 services for non-life-threatening conditions that require care by a  
 11 credentialed practitioner within 24 hours.

12  
 13 For non-contracted practitioners/providers or services provided outside the  
 14 member’s service area, urgent services are requests for medical care or  
 15 treatment/services with respect to which the application of the time periods  
 16 for making non-urgent care determinations:

- 17 • Could seriously jeopardize the life or health of the member or the  
 18 member’s ability to regain maximum function, based on a prudent  
 19 layperson’s judgment; or
- 20 • In the opinion of a practitioner with knowledge of the member’s medical  
 21 condition, would subject the member to severe pain that cannot be  
 22 adequately managed without the care or treatment that is the subject of  
 23 the request.  
 24

25 **Adverse Benefit Determination** – A declination (which includes a denial, reduction, or  
 26 termination of, or a failure to make partial or whole payment) for a benefit,  
 27 including any such declination for that plan.  
 28

29 Additionally, with respect to group health plans, a declination for a benefit  
 30 resulting from the application of any medical necessity review, as well as a  
 31 failure to cover an item or service for which benefits are otherwise provided  
 32 because it is determined to be experimental or investigational or not  
 33 medically necessary or appropriate.  
 34

35 **Deemed Exhaustion of and De Minimis Violations of the Appeals and Grievance**  
 36 **Policy**

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

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

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

7  
8 ASH cannot claim the de minimis exception if its failure to strictly adhere to its appeals  
9 and grievances process is part of a pattern or practice of violations. In these instances, the  
10 appeals and grievance process is deemed exhausted and the Member is entitled to seek  
11 independent review.

12  
13 In the event that ASH fails to strictly adhere to its appeals and grievances policy, a Member  
14 may request a written explanation of the violation from ASH. ASH must provide such an  
15 explanation within 10 days of the Member’s request. ASH’s response must include a  
16 specific description of the basis for asserting that the violation has not caused the internal  
17 appeals and grievances process to be deemed exhausted.

18  
19 If, after a Member has sought independent review of a claim, an independent reviewer or  
20 a court rejects the Member’s request for immediate review because ASH has met the  
21 standards for the de minimis exception, the Member has the right to resubmit an appeal or  
22 grievance to ASH. If this occurs, ASH must provide the Member with a notice of the  
23 opportunity to resubmit an internal appeal or grievance. ASH must provide this notice  
24 within a reasonable time after the independent reviewer or court rejects the Member’s  
25 appeal for immediate review, not to exceed 10 days. Time periods for re-filing an appeal  
26 or grievance begins at the time of the Member’s receipt of such notice.

27  
28 **I. MEMBER APPEALS**

29  
30 **Medical Necessity Appeals**

31 **Overview**

32 ASH provides a reasonable opportunity to Members for a full and fair review of an adverse  
33 benefit determination by offering two (2) stages of appeal. An authorized representative  
34 (see Member definition above) may act on behalf of a member.

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

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

6  
 7 Individuals who were not involved in any previous decisions and who are not subordinates  
 8 of any such individual participate in the appeal determination process. In addition, a health  
 9 care professional engaged in the appeal process for purposes of a consultation will be an  
 10 individual who was not consulted in connection with the adverse benefit determination or  
 11 the subordinate of any such individual. Upon request from a Member, ASH will identify  
 12 the health care professional(s) whose advice was obtained on behalf of ASH in conjunction  
 13 with the member’s adverse benefit determination, without regard to whether the advice was  
 14 relied upon in making the determination.

15  
 16 During the review of an appeal, the reviewers will not give deference to the initial adverse  
 17 determination when making their appeal determinations.

18  
 19 ASH continues to provide coverage and make payment for the currently approved ongoing  
 20 course of treatment while an internal appeal is under review.

21  
 22 **Effect of Making a Medical Necessity Appeal**

23 ASH will not take any action with respect to a member or practitioner that is intended to  
 24 penalize the Member or the member’s practitioner for, or to discourage the Member or the  
 25 member’s practitioner from undertaking an appeal, dispute resolution, or judicial review  
 26 of an adverse benefit determination.

27  
 28 **Submission Timelines**

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

32  
 33 ASH documents the date when it receives an appeal request, and the date of the decision  
 34 notification, in ASH’s proprietary appeals and grievances database. The request is received  
 35 upon arrival to ASH, even if it is not first received by the ASH Appeals and Grievance  
 36 (APG) department.

37  
 38 **Notification Acknowledging Receipt of the Appeal**

39 The Member is sent an acknowledgement letter within five (5) calendar days of receiving  
 40 the appeal. The acknowledgement letter informs the Member that the appeal has been  
 41 received, the date it was received, the availability of language assistance, and the name,  
 42 address, and telephone number of the ASH representative handling the appeal.

1 In the event that the practitioner initiates an appeal, the practitioner must notify the  
 2 member. The practitioner provides additional notice to the member each time he/she  
 3 continues the appeal to the next stage in the appeal process, including any appeal to an  
 4 Independent Utilization Review Organization (IURO).

5  
 6 **Resolution and Notification Timelines**

7 ASH resolves the first stage of a standard pre-service appeal within ten (10) calendar days  
 8 from the receipt of the appeal. ASH resolves the second stage of a standard pre-service  
 9 appeal within 20 business days from the receipt of the appeal.

10  
 11 A second stage appeal may not be initiated by a Member until the first stage appeal is  
 12 exhausted.

13  
 14 In the case that a first stage appeal decision overturns the initial adverse benefit  
 15 determination, ASH will implement the decision.

16  
 17 The period of time within which an appeal determination is required to be made begins at  
 18 the time an appeal is filed with ASH. ASH makes decisions on appeals based on all  
 19 information provided by the Member within the allowed timeframes, along with all  
 20 information previously submitted related to the case.

21  
 22 ASH documentation of the appeal includes:

- 23 • The member’s reason for the appeal of the previous determination
- 24 • Action taken, including, but not limited to:
  - 25 ▪ Previous adverse determination or appeal history;
  - 26 ▪ Follow-up activities associated with the adverse determination and conducted
  - 27 before the current appeal.

28  
 29 Documentation of the appeal is maintained, including the complete investigation of the  
 30 substance of the appeal and any aspects of clinical care involved. During the review of an  
 31 appeal, the reviewers will not give deference to the initial adverse determination when  
 32 making their appeal determinations.

33  
 34 ASH’s response is commensurate with the seriousness and urgency of the appeal. ASH  
 35 directly responds to the reasons given by the member when appealing and addresses new  
 36 information provided by the member or practitioner as part of the appeal process.

37  
 38 **Reviewers**

39 1st Stage: A licensed physician (MD/DO) reviews the appeal.

1 ASH will provide an opportunity for the Member to speak to the licensed physician  
 2 (MD/DO) who rendered the adverse benefit determination regarding an adverse service or  
 3 benefits determination.

4  
 5 2nd Stage: A panel of practitioners including at least one (1) New Jersey licensed physician  
 6 selected by ASH who have not been involved in the adverse benefit determination at issue.  
 7 The Member has the right to be present to pursue his/her appeal before the panel. The  
 8 decision made by the panel is the final decision at this stage.

9  
 10 ASH will allow a contracted practitioner in the same/similar specialty of the treating  
 11 practitioner to participate with the panel in the review of the case if so requested by the  
 12 Member.

13  
 14 In all cases, licensed physicians (MD/DO) adhere to established clinical criteria when  
 15 reviewing appeals.

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

24  
 25 For each appeal, the reviewer will attest that the reviewer has the appropriate  
 26 licensure/certification/registration that typically manages the treatment/services under  
 27 review and the current experience and knowledge to conduct the appeal review. If the  
 28 reviewer does not have the requisite licensure, current experience, or knowledge required,  
 29 they would recuse themselves and inform their manager to reassign the appeal to an  
 30 appropriate reviewer.

31  
 32 **Notification of Appeal Resolution**

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

- 36 • The unique case identifier (reference number);
- 37 • Resolution of the issue;
- 38 • List of reviewers’ titles (name of reviewers’ positions or jobs with the  
 39 organization), qualifications (clinical credentials, e.g., DC, PT) and the specialty  
 40 (e.g., chiropractor, physical therapist) of participants in the appeal review;
- 41 • Upon request, the name(s) of the reviewer(s);

- 1 • A clear and concise explanation in culturally and linguistically appropriate
- 2 language of reasons for the determination;
- 3 • Clinical rationale associated with the decision including the following:
- 4 ○ The internal rule, guideline, protocol, benefit provision or specific criterion
- 5 used as it relates to the member’s condition relied upon in making the
- 6 determination; or
- 7 • A statement that such rule, guideline, protocol, benefit provision, or other similar
- 8 criterion was relied upon in making the determination and a statement that a copy
- 9 of such will be provided to the Member, upon request and free of charge, by
- 10 contacting the Customer Service Department at (800) 678-9133 or on-line at
- 11 www.ashlink.com;
- 12 • A notice regarding the availability of language assistance; and
- 13 • Notification that the Member is entitled to receive, upon request and free of charge,
- 14 reasonable access to and copies of documents relevant to the appeal.

15  
16 Notification of an adverse appeal decision will also include the following:

- 17 • An explanation of the scientific or clinical judgment for the determination, applying
- 18 the terms of ASH to the member’s medical circumstances if the adverse benefit
- 19 determination is based on the medical necessity or experimental treatment or
- 20 similar exclusion or limitation;
- 21 • The reason for upholding the appeal decision in language that is specific to the
- 22 member’s condition;
- 23 • Language that is easy to understand, so the Member understands why ASH upheld
- 24 the appeal decision and has enough information to file the next appeal;
- 25 • A description of the Member’s further appeal rights including notification that the
- 26 Member is given 45 calendar days to submit to the next level of appeal, if
- 27 applicable;
- 28 • If the second stage appeal results in an adverse benefit determination, ASH will
- 29 provide notification of the Member’s right to an external review through an
- 30 Independent Utilization Review Organization (IURO) and/or a Medicaid Fair
- 31 Hearing, as applicable, including notification that the Member is given four (4)
- 32 months to submit an appeal request as designated by the New Jersey Department
- 33 of Banking and Insurance through the Maximus New Jersey IHCAP Portal as well
- 34 as the specific instructions to initiate an external review.
- 35 • Information regarding the availability of, and contact information for, any
- 36 applicable office of health insurance consumer assistance or ombudsman to assist
- 37 members with the appeals and independent review processes;
- 38 • Information regarding the availability of diagnosis and treatment codes and
- 39 descriptions; and
- 40 • As applicable, additional member health information.

1 The following information is documented in ASH’s electronic database:

- 2 • The type of appeal (standard, expedited);
- 3 • Date appeal was received by ASH;
- 4 • Date appeal was received in ASH’s Appeals and Grievances Department;
- 5 • Time appeal was received, if available;
- 6 • Party filing appeal (member, authorized representative, practitioner);
- 7 • Received in writing, verbally, or electronically;
- 8 • Reason/category of the appeal;
- 9 • Member information (name, DOB, address [if available], ID number, contract
- 10 name, group name, effective date, term date [if applicable], benefit information,
- 11 delegation information);
- 12 • Practitioner information (practitioner ID number, name, address, status [active or
- 13 termed], par date, clinical performance tier level). Notes for each case that
- 14 document the details of the appeal and any subsequent actions taken in resolving
- 15 the appeal;
- 16 • Documentation of all correspondence related to the case that was sent by ASH (e.g.,
- 17 acknowledgement letter, medical records request, inquiry letter, resolution letter);
- 18 and
- 19 • Resolution of the case, including names of reviewers and/or committee that
- 20 reviewed the case.

21  
22 **Information Provided Upon the Designated Practitioner’s Request**

23 ASH will provide a written description of the appeal process and ASH’s decision on an  
24 appeal to the practitioner upon request and upon the conclusion of each stage of the appeal  
25 process when the practitioner is making the appeal on behalf of the member with the  
26 member’s consent.

27  
28 **Independent Stages of Review**

29 If the Member is not satisfied with the determination after the internal stages of appeal are  
30 completed, the Member has the option to pursue independent stages of appeal. Additional  
31 information regarding the Member’s independent stages of review is available in the  
32 Independent Stages of Review, Medical Necessity Appeals section of this policy.

33  
34 **Medical Necessity Expedited Appeals**

35 **Overview**

36 ASH provides reasonable opportunity to Members for a full and fair review of a pre-service  
37 adverse benefit determination by offering two (2) internal stages of review for expedited  
38 appeals. An authorized representative (see Member definition above) may act on behalf of  
39 a member.

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

9  
 10 When making an appeal decision of an adverse benefit determination with regard to  
 11 whether a particular treatment, drug, or other item is experimental, investigational, or not  
 12 medically necessary or appropriate, ASH will consult with a health care professional who  
 13 has appropriate training and experience in the field of medicine involved in the medical  
 14 judgment.

15  
 16 Individuals who were not involved in any previous decisions and who are not subordinates  
 17 of any such individual participate in the appeal determination process. In addition, a health  
 18 care professional engaged in the appeal process for purposes of a consultation will be an  
 19 individual who was not consulted in connection with the adverse benefit determination or  
 20 the subordinate of any such individual. Upon request from a Member, ASH will identify  
 21 the health care professional(s) whose advice was obtained on behalf of ASH in conjunction  
 22 with the member’s adverse benefit determination, without regard to whether the advice was  
 23 relied upon in making the determination.

24  
 25 ASH continues to provide coverage and make payment for the currently approved ongoing  
 26 course of treatment while an internal appeal is under review.

### 27 28 **Effect of Making a Medical Necessity Appeal**

29 ASH will not take any action with respect to a member or practitioner that is intended to  
 30 penalize the Member or the member’s practitioner for, or to discourage the Member or the  
 31 member’s practitioner from undertaking an appeal, dispute resolution, or judicial review  
 32 of an adverse benefit determination.

### 33 34 **Submission Timelines**

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

39  
 40 ASH documents the date when it receives an appeal request, and the date of the decision  
 41 notification, in ASH’s proprietary appeals and grievances database. The request is received  
 42 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 at each stage of appeal as soon as possible, but no later than 72 hours from the receipt of the appeal. 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 of the decision. 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**

1st Stage: A licensed physician (MD/DO) reviews the appeal.

ASH will provide an opportunity for the Member to speak to the licensed physician (MD/DO) who rendered the adverse benefit determination regarding an adverse service or benefits determination.

2nd Stage: A panel of practitioners including at least one (1) New Jersey licensed physician selected by ASH who have not been involved in the adverse benefit determination at issue. The Member has the right to be present to pursue his/her appeal before the panel. The decision made by the panel is the final decision at this stage.

ASH will allow a contracted practitioner in the same/similar specialty of the treating practitioner to participate with the panel in the review of the case if so requested by the member or his/her designated practitioner.

In all cases, licensed physicians (MD/DO) adhere to established clinical criteria when reviewing appeals.

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.

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

7  
 8 **Notification of Appeal Resolution**

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

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

32  
 33 Notification of an adverse appeal decision will also include the following:

- 34 • An explanation of the scientific or clinical judgment for the determination, applying  
 35 the terms of ASH to the member’s medical circumstances if the adverse benefit  
 36 determination is based on the medical necessity or experimental treatment or  
 37 similar exclusion or limitation;
- 38 • The reason for upholding the appeal decision in language that is specific to the  
 39 member’s condition;
- 40 • Language that is easy to understand, so the Member understands why ASH upheld  
 41 the appeal decision and has enough information to file the next appeal;

- 1 • A description of the Member’s further appeal rights;
- 2 • A statement that Members are not responsible for any charges or fees associated
- 3 with independent dispute resolution options, unless state law mandates that
- 4 members pay an IRO filing fee or the member is in a self-funded plan;
- 5 • Information regarding the availability of, and contact information for, any
- 6 applicable office of health insurance consumer assistance or ombudsman to assist
- 7 members with the appeals and independent review processes;
- 8 • Information regarding the availability of diagnosis and treatment codes and
- 9 descriptions; and
- 10 • As applicable, additional member health information.
- 11 • If the second stage appeal results in an adverse benefit determination, ASH will
- 12 provide notification of the Member’s right to an external review through an
- 13 Independent Utilization Review Organization (IURO) and/or a Medicaid Fair
- 14 Hearing, as applicable, including notification that the Member is given four (4)
- 15 months to submit an appeal request as designated by the New Jersey Department
- 16 of Banking and Insurance through the Maximus New Jersey IHCAP Portal as well
- 17 as the specific instructions to initiate an external review.

18  
19 The following information is documented in ASH’s electronic database:

- 20 • The type of appeal (standard, expedited);
- 21 • Date appeal was received by ASH;
- 22 • Date appeal was received in ASH’s Appeals and Grievances Department;
- 23 • Time appeal was received, if available;
- 24 • Party filing appeal (member, authorized representative, practitioner);
- 25 • Received in writing, verbally, or electronically;
- 26 • Reason/category of the appeal;
- 27 • Member information (name, DOB, address [if available], ID number, contract
- 28 name, group name, effective date, term date [if applicable], benefit information,
- 29 delegation information);
- 30 • Practitioner information (practitioner ID number, name, address, status [active or
- 31 termed], par date, clinical performance tier level);
- 32 • Notes for each case that document the details of the appeal and any subsequent
- 33 actions taken in resolving the appeal;
- 34 • Documentation of all correspondence related to the case that was sent by ASH (e.g.,
- 35 acknowledgement letter, medical records request, inquiry letter, resolution letter);
- 36 and
- 37 • Resolution of the case, including names of reviewers and/or committee that
- 38 reviewed the case.

1 **Information Provided Upon the Designated Practitioner’s Request**

2 ASH will provide a written description of the appeal process and ASH’s decision on an  
3 appeal to the practitioner upon request and upon the conclusion of each stage of the appeal  
4 process when the practitioner is making the appeal on behalf of the member with the  
5 member’s consent.

6  
7 **Independent Stages of Review**

8 If the Member is not satisfied with the determination after the internal stages of appeal is  
9 completed, the Member has the option to pursue independent stages of appeal. Additional  
10 information regarding the Member’s independent stages of review is available in the  
11 Independent Stages of Review, Medical Necessity Appeals section of this policy.

12  
13 **II. INDEPENDENT STAGES OF REVIEW**

14  
15 **Medical Necessity Appeals**

16 **Overview**

17 Member may appeal standard and expedited internal medical necessity adverse benefit  
18 determinations to an external review. This may include an Independent Utilization Review  
19 Organization (IURO) and/or a Medicaid Fair Hearing, as applicable.

20  
21 NJ FamilyCare and Medicaid beneficiary members are permitted to pursue either or both  
22 a Medicaid and an external appeal to an IURO. All other members seeking an external  
23 appeal may pursue only the process of an appeal to an IURO.

24  
25 When a practitioner has provided services to a NJ FamilyCare or Medicaid beneficiary  
26 member, the Member may request a Medicaid Fair Hearing with the New Jersey  
27 Department of Human Services. A Medicaid Fair Hearing may be requested in addition to,  
28 or in place of, an external appeal to an IURO.

29  
30 A member and/or practitioner may seek an expedited external appeal to an IURO for review  
31 of adverse determinations regarding services deemed to be urgent or an emergency. In such  
32 cases, the IURO shall complete its review within no more than 48 hours following its  
33 receipt of the appeal. If the IURO’s determination of the appeal provided within no more  
34 than 48 hours was not in writing, the IURO will provide written confirmation of its  
35 determination within 48 hours of providing the verbal determination.

36  
37 To initiate an external review to an IURO, the Member may submit an external appeal  
38 application, within four (4) months after receipt of ASH’s final internal adverse benefit

determination, either electronically through the Maximus New Jersey IHCAP Portal at <https://njihcap.maximus.com>, via fax at (585) 425-5296 or by mail to:

Maximus Federal  
 Attn: State Appeals/NJ IHCAP  
 3750 Monroe Avenue, Suite 705  
 Pittsford, NY 14534

The IURO’s determination will be binding on ASH and/or the health plan, member and practitioner, except to the extent that other remedies are available to either party under state or Federal law.

ASH or the health plan will comply with the decision of an IURO in 10 days or less according to the exigencies of the case.

A Member may submit an external appeal to Maximus within four (4) months of receipt of the written notice of denial of ASH’s second stage appeal. The covered person shall pay an application processing fee of \$25. The commissioner may reduce or waive the fee in the case of financial hardship. The health care practitioner acting on the covered person’s behalf shall bear all costs associated with the appeal that are normally paid by the covered person.

By regulation, the IURO has 45 days (48 hours of receipt of an emergency or urgent care appeal request for external review) from the date that it receives all of the information it believes is necessary for it to make a thorough review of the matter to render a final decision. Once a determination has been made on the appeal, the Member will receive an email, indicating that they may retrieve the determination letter from the Documents section on the Case Details page in the Maximus New Jersey IHCAP Portal. (<https://njihcap.maximus.com>)

The decision of the IURO to reverse or modify ASH’s decision is binding upon ASH. ASH will comply with the decision within ten (10) business days or sooner if the medical exigencies of the case warrant a more rapid response.

**Right to Arbitration**

If the Member is not satisfied with the determination of the appeal after the Independent Health Care Appeal Program review, the Member may initiate an independent stage of appeal consisting of arbitration through the American Arbitration Association (the Association). These rights are applicable where arbitration is included in a member’s/insured’s plan document. To obtain more information about the Association call the Association at (877) 495-4185. The Association’s arbitration determination will be binding.

1 **Right to Civil Action**

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

5  
6 **III. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS**

7  
8 **Overview**

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

15  
16 Individuals who were not involved in any previous decisions and who are not subordinates  
17 of any such individual participate in the appeal determination process.

18  
19 **Effect of Making an Expedited Medical Necessity Appeal**

20 ASH will not take any action with respect to a member or a practitioner that is intended to  
21 penalize the Member or the member’s practitioner for, or to discourage the Member or the  
22 member’s practitioner from undertaking an appeal, dispute resolution, or judicial review  
23 of an adverse benefit determination.

24  
25 **Submission Timelines**

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

29  
30 A Member may submit a written appeal by letter or ASH appeal form, or a verbal appeal  
31 in connection with 1) a denial of or failure to pay for a service or 2) a determination as to  
32 whether a benefit is covered under the member’s contract.

33  
34 Upon receipt of the appeal ASH will provide notice specifying what information must be  
35 provided in order for ASH to render a decision on the appeal.

36  
37 **Notification Acknowledging Receipt of the Appeal**

38 The Member is sent an acknowledgement letter within five (5) calendar days of receiving  
39 the appeal. The acknowledgement letter informs the Member that the appeal has been  
40 received, the date it was received, the availability of language assistance, and the name,  
41 address, and telephone number of the ASH representative handling the appeal.

1 **Resolution and Notification Timelines**

2 ASH resolves and notifies the Member of the determination at each stage of a pre-service  
 3 appeal within 15 calendar days from the receipt of the appeal. ASH resolves and notifies  
 4 the Member of the determination at each stage of a post-service appeal within 30 calendar  
 5 days from the receipt of the appeal.

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

11  
 12 Documentation of the appeal is maintained, including the complete investigation of the  
 13 substance of the appeal and any aspects of clinical care involved.

14  
 15 **Reviewers**

16 1<sup>st</sup> Stage: A minimum of two (2) operational managers will review the appeal and make a  
 17 determination.

18 2<sup>nd</sup> Stage: The Administrative Review Committee (ARC) will review the appeal and make  
 19 the final determination at this level.

20  
 21 **Notification of Appeal Resolution**

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

- 24 • The unique case identifier (reference number);
- 25 • Statement of the reviewer's understanding of the pertinent facts of the appeal;
- 26 • The detailed reasons for the determination;
- 27 • Reference to the evidence or documentation used as the basis for the decision and,  
 28 in cases involving a denial of clinical services, instructions for requesting a written  
 29 statement of the clinical rationale, including the clinical review criteria used;
- 30 • Resolution of the issue;
- 31 • List of titles, qualifications and the specialty of participants in the appeal review;
- 32 • Upon request, the name(s) of the reviewer(s);
- 33 • A notice regarding the availability of language assistance; and
- 34 • Notification that the member is entitled to receive, upon request, reasonable access  
 35 to and copies of documents relevant to the appeal.

36  
 37 Notification of an adverse appeal decision will also include the following:

- 38 • A clear and concise explanation in culturally and linguistically appropriate  
 39 language of reasons for the determination;

- 1 • Rationale associated with the decision including the following:
  - 2 ○ The internal rule, guideline, protocol, benefit provision or other similar criterion
  - 3 relied upon in making the determination; or
  - 4 ○ A statement that such rule, guideline, protocol, benefit provision, or other
  - 5 similar criterion was relied upon in making the determination and a statement
  - 6 that a copy of such will be provided to the Member, upon request and free of
  - 7 charge by contacting the Customer Service Department at (800) 678-9133 or
  - 8 on-line at www.ashlink.com.
- 9 • A description of the Member’s further appeal rights including notification that the
- 10 Member is given 60 business days to submit to the next stage of appeal.

11  
12 **Voluntary Stages of Review**

13 If the Member is not satisfied with the determination after review by the ARC, the Member  
14 has the option to pursue voluntary stages of appeal. Additional information regarding the  
15 member’s voluntary stages of review is available in the Voluntary Stages of Review,  
16 Coverage Disputes/Administrative Appeals section of this policy.

17  
18 **IV. COVERAGE DISPUTES/**  
19 **ADMINISTRATIVE EXPEDITED APPEALS**  
20

21 **Overview**

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

28  
29 Individuals who were not involved in any previous decisions and who are not subordinates  
30 of any such individual may participate in the appeal determination process. In addition, a  
31 health care professional engaged in the appeal process for purposes of a consultation will  
32 be an individual who was not consulted in connection with the adverse benefit  
33 determination or the subordinate of any such individual.

34  
35 **Effect of Making an Expedited Medical Necessity Appeal**

36 ASH will not take any action with respect to a member or a practitioner that is intended to  
37 penalize the member, the member’s designee, or the member’s practitioner for, or to  
38 discourage the member, the member’s designee, or the member’s practitioner from  
39 undertaking an appeal, dispute resolution, or judicial review of an adverse benefit  
40 determination.

1 **Submission Timelines**

2 A Member may submit written or verbal expedited coverage disputes/administrative  
 3 appeals when a delay would significantly increase the risk to a member’s health.

4  
 5 **Resolution and Notification Timelines**

6 ASH resolves and notifies the Member verbally of the determination at each stage of appeal  
 7 as soon as possible, and within 36 hours from the receipt of the appeal, not to exceed 72  
 8 hours to complete both stages of review. Written confirmation of the determination will be  
 9 communicated within two (2) business days after the verbal notification.

10  
 11 The period of time within which an appeal determination is required to be made begins at  
 12 the time an appeal is filed, without regard to whether all the information necessary to make  
 13 a determination accompanies the filing.

14  
 15 Documentation will be maintained of the substance of the Member appeal, including  
 16 documentation of a full investigation of the substance of the appeal and any aspects of  
 17 clinical care involved.

18  
 19 **Reviewers**

20 1st Stage: A minimum of two (2) operational managers will review the appeal.

21 2nd Stage: The Administrative Review Committee (ARC) will review the appeal and make  
 22 the final decision at this stage.

23  
 24 **Notification of Appeal Resolution**

25 After a decision is made regarding the appeal, a resolution letter is sent to the Member.

26  
 27 The notification letter includes the following information:

- 28 • Statement of the reviewer's understanding of the pertinent facts of the appeal;
- 29 • The detailed reasons for the determination;
- 30 • Reference to the evidence or documentation used as the basis for the decision and,  
 31 in cases involving a denial of clinical services, instructions for requesting a written  
 32 statement of the clinical rationale, including the clinical review criteria used;
- 33 • Resolution of the issue;
- 34 • List of titles and qualifications of participants in the appeal review; and
- 35 • Notification that the member is entitled to receive, upon request, reasonable access  
 36 to and copies of documents relevant to the appeal.

37  
 38 Notification of an adverse appeal decision will also include the following:

- 39 • A clear and concise explanation in easily understandable language of reasons for  
 40 determination;

- 1 • Reasoning associated with the decision including the following:
  - 2 ○ The internal rule guideline, protocol, benefit provision or other similar criterion
  - 3 relied upon in making the determination; or
  - 4 ○ A statement that such rule, guideline, protocol, benefit provision, or other
  - 5 similar criterion was relied upon in making the determination and a statement
  - 6 that a copy of such will be provided to the member, upon request and free of
  - 7 charge.
- 8 • An explanation of the scientific or clinical judgment for the determination, applying
- 9 the terms of the plan to the Member’s medical circumstances, if applicable, if the
- 10 adverse benefit determination is based on the medical necessity or experimental
- 11 treatment or similar exclusion or limitation.

12  
13 The following information is documented in ASH’s electronic database:

- 14 • The type of appeal (standard, expedited);
- 15 • Date appeal was received by ASH;
- 16 • Date appeal was received in ASH’s Appeals and Grievances Department;
- 17 • Time appeal was received, if available;
- 18 • Party filing appeal (member, authorized representative, practitioner);
- 19 • Received in writing, verbally, or electronically;
- 20 • Reason/category of the appeal;
- 21 • Member information (name, DOB, address [if available], ID number, contract
- 22 name, group name, effective date, term date [if applicable], benefit information,
- 23 delegation information);
- 24 • Practitioner information (practitioner ID number, name, address, status [active or
- 25 termed], par date, clinical performance tier level);
- 26 • Notes for each case that document the details of the appeal and any subsequent
- 27 actions taken in resolving the appeal;
- 28 • Documentation of all correspondence related to the case that was sent by ASH (e.g.,
- 29 acknowledgement letter, medical records request, inquiry letter, resolution letter);
- 30 and
- 31 • Resolution of the case, including names of reviewers and/or committee that
- 32 reviewed the case.

33  
34 **Voluntary Stages of Review**

35 If the Member is not satisfied with the determination after the stages of appeal are  
36 completed, the Member has the option to pursue voluntary stages of appeal. Additional  
37 information regarding the member’s voluntary stages of review is available in the  
38 “Voluntary Stages of Review – Coverage Disputes/Administrative Appeals” section of this  
39 policy.

**V. VOLUNTARY STAGES OF REVIEW**

**Coverage Disputes/Administrative Appeals**

**Overview**

ASH provides Members with the option to pursue voluntary stages of appeal. If the appeal involves a benefit coverage limitation, other than medical necessity, the Member may submit a request for a voluntary stage 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 stage 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.

- 1 • A description of the Member’s further appeal rights, including arbitration and civil  
2 action.

3

4 **Right to Arbitration**

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

10

11 **Right to Civil Action**

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

15

16 **VI. MEMBER GRIEVANCES**

17

18 **Quality of Care Grievances**

19 **Overview**

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

27

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

30

31 **Submission Timeline**

32 A Member may submit written or verbal grievances to the Customer Service Department.  
33 If a Member is dissatisfied with the quality of care received, the Member may file a  
34 grievance within 180 days of the incident.

35

36 A customer service representative registers the complaint to document the issue and  
37 resolution actions including:

- 38 • Substance of the complaint,
- 39 • Actions taken to investigate and resolve the issue; and
- 40 • Any pertinent aspects of clinical care.

1 **Notification Acknowledging Receipt of the Grievance**

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

6  
 7 **Resolution Timeline**

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

9  
 10 Grievances involving clinical urgency are responded to within two (2) business days of  
 11 receiving all necessary information.

12  
 13 **Reviewers**

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

18  
 19 **Notification of Grievance Resolution**

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

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

32  
 33 For grievances which result in an adverse benefit determination the Member is given the  
 34 opportunity to appeal the grievance determination with the plan in addition to the right to  
 35 contact the New Jersey Department of Banking and Insurance (NJDOBI). The grievance  
 36 may be submitted to:

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

1 Or by calling: (888) 393-1062

2  
3 The following information is documented in ASH’s electronic database:

- 4 • The type of grievance;
- 5 • Date grievance was received by ASH;
- 6 • Date grievance was received in ASH’s Appeals and Grievances Department;
- 7 • Time grievance was received, if available;
- 8 • Party filing grievance (member, authorized representative, practitioner);
- 9 • Received in writing, verbally, or electronically;
- 10 • Reason/category of the grievance;
- 11 • Member information (name, DOB, address [if available], ID number, contract
- 12 name, group name, effective date, term date [if applicable], benefit information,
- 13 delegation information);
- 14 • Practitioner information (practitioner ID number, name, address, status [active or
- 15 termed], par date, clinical performance tier level);
- 16 • Notes for each case that document the details of the grievance and any subsequent
- 17 actions taken in resolving the grievance;
- 18 • Documentation of all correspondence related to the case that was sent by ASH (e.g.,
- 19 acknowledgement letter, medical records request, inquiry letter, resolution letter);
- 20 and
- 21 • Resolution of the case, including names of reviewers and/or committee that
- 22 reviewed the case.

23  
24 **All other Types of Grievances**

25 **Quality of Service and Access to Care Grievances**

26 **Overview**

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

31  
32 A qualified individual will investigate the Member’s issue.

33  
34 **Submission Timeline**

35 A Member may submit written or verbal grievances to the Customer Service Department.  
36 If a Member is dissatisfied with the quality of service or access to care, the Member may  
37 file a grievance at any time following the incident giving rise to the complaint.

38  
39 **Notification Acknowledging Receipt of the Grievance**

40 The Member is sent an acknowledgement letter within five (5) calendar days of receiving  
41 the grievance. The acknowledgement letter informs the Member that the grievance has

1 been received, the date it was received, the availability of language assistance, and the  
2 name, address, and telephone number of the ASH representative handling the grievance.

3  
4 **Resolution Timeline**

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

6  
7 **Reviewers**

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

10  
11 Grievances involving clinical urgency are responded to within two (2) business days of  
12 receiving all necessary information.

13  
14 **Notification of Grievance Resolution**

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

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

26  
27 For grievances which result in an adverse benefit determination the Member is given the  
28 opportunity to appeal the grievance determination with the plan in addition to the right to  
29 contact the New Jersey Department of Banking and Insurance (NJDOBI). The grievance  
30 may be submitted to:

31  
32 New Jersey Department of Banking and Insurance  
33 Office of Managed Care  
34 Consumer Protection Services  
35 P.O. Box 329  
36 Trenton, NJ 08625-0329

37  
38 Or by calling: (888) 393-1062

39  
40 The following information is documented in ASH’s electronic database:

- 41 • The type of grievance;
- 42 • Date grievance was received by ASH;

- 1 • Date grievance was received in ASH’s Appeals and Grievances Department;
- 2 • Time grievance was received, if available;
- 3 • Party filing grievance (member, authorized representative, practitioner);
- 4 • Received in writing, verbally, or electronically;
- 5 • Reason/category of the grievance;
- 6 • Member information (name, DOB, address [if available], ID number, contract
- 7 name, group name, effective date, term date [if applicable], benefit information,
- 8 delegation information);
- 9 • Practitioner information (practitioner ID number, name, address, status [active or
- 10 termed], par date, clinical performance tier level);
- 11 • Notes for each case that document the details of the grievance and any subsequent
- 12 actions taken in resolving the grievance;
- 13 • Documentation of all correspondence related to the case that was sent by ASH (e.g.,
- 14 acknowledgement letter, medical records request, inquiry letter, resolution letter);
- 15 and
- 16 • Resolution of the case, including names of reviewers and/or committee that
- 17 reviewed the case.

18  
19 **COMMUNICATION SERVICES**

20 **Availability During Business Hours**

- 21 1. Customer service staff are available at from 5:00 a.m. to 6:00 p.m. PST during normal
- 22 business days to receive inbound communications regarding medical necessity review
- 23 issues.
- 24 • Customer service staff respond to general clinical services and administrative
- 25 inquiries, which may include fax, electronic or telephone communications,
- 26 including voicemail.
- 27 • Customer service staff document inbound communications and their response.
- 28 • Customer service staff may refer specific inbound clinical services communications
- 29 to Clinical Services Administration staff or clinical quality evaluators, as
- 30 appropriate.
- 31
- 32 2. Clinical Services Administration staff and clinical quality evaluators are available at
- 33 least eight (8) hours a day during normal business hours to receive inbound
- 34 communication regarding clinical services issues. Clinical Services Administration
- 35 staff and clinical quality evaluators provide telephone and fax numbers and/or
- 36 electronic access to practitioners for inbound communication.
- 37
- 38 3. Clinical Services Administration staff and clinical quality evaluators are available at
- 39 least eight (8) hours a day during normal business hours to perform outbound
- 40 communication and to respond to inquiries about clinical services.

- 1 • Outbound communications may include directly speaking with practitioners and
- 2 members or fax, electronic, or other telephonic communications, including e-mail
- 3 and voicemail.
- 4 • Staff identifies themselves by name, title, and organization name when initiating or
- 5 returning calls regarding clinical services issues.
- 6 • Inquiries and responses are documented in the ASH proprietary communication
- 7 log. ASH provides a toll-free number for calls regarding clinical services issues and
- 8 the ability to speak to a clinical quality evaluator.

9  
10 **Availability Outside Normal Business Hours**

- 11 1. ASH provides a toll-free number and e-mail address for communications regarding
- 12 clinical services issues.
- 13
- 14 2. Customer service, Clinical Services Administration, and clinical quality evaluators
- 15 retrieve and triage or respond to all routine, non-urgent messages no later than the next
- 16 business day.
- 17
- 18 3. A contracted answering service screens after-hours calls. If a member or practitioner
- 19 states the issue is urgent, ASH’s “on call” customer service supervisor is contacted.
- 20 The “on call” supervisor returns the member’s or practitioner’s call and provides
- 21 assistance. If the issue is of an urgent clinical nature, an ASH senior clinician is paged
- 22 immediately and notified of the issue for resolution. The member or practitioner call
- 23 and resolution are documented in the ASH proprietary communication log the next
- 24 business day.

25  
26 Capacity of voicemail service, answering machine, or e-mailbox is adjusted as needed to

27 accept the volume of incoming calls.

28  
29 **VII RECORD KEEPING**

30  
31 All documentation of member appeals and grievances will be retained for a minimum of

32 seven (7) years from the date of receipt. Once the retention period has expired for a given

33 record, that record will be destroyed in accordance with the ASH Document Disposal

34 policy.

35  
36 ASH maintains records for each appeal and grievance that includes the following:

- 37 • The name of the member, provider and/or practitioner rendering service;
- 38 • Copies of all correspondence from the Member, provider and practitioner rendering
- 39 service and ASH regarding the appeal and grievance;
- 40 • Dates of appeal and grievance reviews,

- 1 • Documentation of actions taken, including previous adverse determination and/or
- 2 appeal history and follow up activities associated with adverse determinations and
- 3 conducted before the current appeal,
- 4 • Final resolution; and
- 5 • The name and credentials of the peer clinical quality evaluator that reviewed the
- 6 appeal, if applicable.

7

8 Applicable meeting minutes are reviewed, signed by the chairperson, and maintained as

9 the official meeting record.

10

11 **Centers for Medicare and Medicaid Services (CMS)**

12 Effective January 1, 2006, Operational Policy Letter (OPL) 98.077 (revised) requires that

13 ASH, as a Downstream Provider, comply with the following requirements:

14

15 ASH agrees to give the Department of Health and Human Services (HHS), and the General

16 Accounting Office (GAO) or their designees the right to audit, evaluate, inspect books,

17 contracts, medical records, patient care documentation, other records of subcontractors, or

18 related entities for the later of ten (10) years, or for periods exceeding ten (10) years, for

19 reasons specified in the federal regulation, for Members enrolled in a Medicare Advantage

20 Organization (MAO) [42 CFRs 422.502 (e) (2), (3) and (i) (2)].

21

22 This increase in the duration of the record retention period applies to all new records as well

23 as to all records required to be retained under the Prior Addendum as of the date first written

24 above.