

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

2

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

4

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

6

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

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

4  
5 **Definitions:**

6 **Appeal -**

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

9  
10 **Medical Necessity -** Any appeal resulting from the adverse benefit determination  
11 of treatment/services relative to medical necessity.

12  
13 **Medical Necessity Expedited -** An appeal that is resolved expeditiously if the  
14 member’s health or ability to function could be seriously harmed by waiting  
15 for a determination to be made under the normal Medical Necessity Appeal  
16 Timeframe, or the practitioner indicates there is an urgent need for  
17 continued care.

18  
19 **Grievance -** A formal expression of dissatisfaction, not involving an ASH decision, that  
20 involves quality of care, quality of service, or access to care.

21  
22 **Member -** A member or a member’s authorized representative, and a provider or  
23 practitioner, if the provider or practitioner is acting on behalf of the member  
24 and with the member’s written consent, collectively referred to as the  
25 “Member” throughout this policy.

26  
27 **Pre-Service -** An appeal received prior to the provision of care; or after treatment/services  
28 have been initiated, but before the ending date of service.

29  
30 **Post-Service -** An appeal that involves submission of treatment/services received after the  
31 provision of care.

32  
33 **Adverse Benefit Determination –** A declination (which includes a denial, reduction, or  
34 termination of, or a failure to make partial or whole payment) for a benefit,  
35 including any such declination for that plan.

36  
37 Additionally, with respect to group health plans, a declination for a benefit  
38 resulting from the application of any medical necessity review, as well as a  
39 failure to cover an item or service for which benefits are otherwise provided  
40 because it is determined to be experimental or investigational or not  
41 medically necessary or appropriate.

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

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

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

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

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

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

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

**I. MEMBER APPEALS**

**Medical Necessity Appeals**

**Overview**

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

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. If ASH considers or relies on any new or additional evidence in  
7 making its determination, ASH will provide that evidence to the member free of charge  
8 and as soon as possible, in advance of the determination.

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

27  
28 ASH would continue to provide coverage and make payment for the currently approved  
29 ongoing course of treatment while an internal appeal is under review.

### 30 **Submission Timelines**

31  
32 A Member may submit written or verbal appeals. If a Member disagrees with an initial  
33 adverse benefit determination, the Member may file an initial appeal within 180 days of  
34 receiving notification of the adverse benefit determination.

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

1 **Notification Acknowledging Receipt of the Appeal**

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

8  
9 **Resolution and Notification Timelines**

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

15  
16 In the case that an appeal decision overturns the initial adverse benefit determination, ASH  
17 will implement the decision.

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

23  
24 ASH documentation of the appeal includes:

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

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

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

39  
40 **Reviewers**

41 A clinical director or senior clinician in the same profession and in a same/similar specialty  
42 as typically manages the health care service or treatment under review evaluates the appeal

1 and makes a determination. If the clinical director or senior clinician makes a decision in  
2 favor of the member, the appeal is considered resolved.

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

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

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

21  
22 For each appeal, the reviewer will attest that the reviewer has the appropriate  
23 licensure/certification/registration that typically manages the treatment/services under  
24 review and the current experience and knowledge to conduct the appeal review. If the  
25 reviewer does not have the requisite licensure, current experience, or knowledge required,  
26 they would recuse themselves and inform their manager to reassign the appeal to an  
27 appropriate reviewer.

28  
29 At any stage during the appeal process, ASH may, at the request of the member, appoint a  
30 staff member to assist the Member with their appeal.

### 31 **Notification of Appeal Resolution**

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

- 36 • Resolution of the issue;
- 37 • List of reviewers' titles (name of reviewers' positions or jobs with the  
38 organization), qualifications (clinical credentials, e.g., DC, PT) and the specialty  
39 (e.g., chiropractor, physical therapist) of participants in the appeal review;
- 40 • Upon request, the name(s) of the reviewer(s);
- 41 • A clear and concise explanation in culturally and linguistically appropriate  
42 language of reasons for the determination;

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

13  
14 Notification of an adverse appeal decision will also include the following:

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

33  
34 If the outcome of the appeal is adverse to the member, the written notice will include the

35 right of the Member to appeal the decision of the second level review committee to the

36 Commissioner of Insurance or Director, Arkansas insurance Department, Consumer

37 Services, 1 Commerce Way, Suite 102, Little Rock, AR 72202, (501) 371-2640 or (800)

38 852-5494.

39  
40 For pre-service appeals, the name, title, address, toll-free telephone number and telephone

41 extension of the Arkansas-licensed physician (MD/DO) responsible for making the adverse

determination, along with a listing of each state in which the Arkansas-licensed physician (MD/DO) is licensed and the license number issued by each state.

**Independent Levels of Review**

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

**Medical Necessity Expedited Appeals**

**Overview**

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

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

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

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

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



1 **Submission Timelines**

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

6  
7 ASH documents the date when it receives an appeal request, and the date of the decision  
8 notification, in ASH’s proprietary appeals and grievances database. The request is received  
9 upon arrival to ASH, even if it is not first received by the ASH Appeals and Grievance  
10 (APG) department.

11  
12 **Resolution and Notification Timelines**

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

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

24  
25 Documentation of the appeal is maintained, including the complete investigation of the  
26 substance of the appeal and any aspects of clinical care involved.

27  
28 **Reviewers**

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

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

38  
39 For pre-service appeals, if the clinical director or senior clinician makes a decision that is  
40 not in favor of the member, the appeal is automatically sent for review by an Arkansas-  
41 licensed physician (MD/DO). The appeal decision made by the Arkansas-licensed  
42 physician (MD/DO) is the final decision at this appeal level.

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

8  
 9 For each appeal, the reviewer will attest that the reviewer has the appropriate  
 10 licensure/certification/registration that typically manages the treatment/services under  
 11 review and the current experience and knowledge to conduct the appeal review. If the  
 12 reviewer does not have the requisite licensure or current experience and/or knowledge  
 13 required, they would recuse themselves and inform their manager to reassign the appeal to  
 14 an appropriate reviewer.

15  
 16 At any stage during the appeal process, ASH may, at the request of the member, appoint a  
 17 staff member to assist the Member with their appeal.

### 18 19 **Notification of Appeal Resolution**

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

- 23 • Resolution of the issue;
- 24 • List of reviewers' titles (name of reviewers' positions or jobs with the  
 25 organization), qualifications (clinical credentials, e.g., DC, PT) and the specialty  
 26 (e.g., chiropractor, physical therapist) of participants in the appeal review;
- 27 • Upon request, the name(s) of the reviewer(s);
- 28 • A clear and concise explanation in culturally and linguistically appropriate  
 29 language of reasons for the determination;
- 30 • Clinical rationale associated with the decision including the following:
  - 31 ○ The internal rule, guideline, protocol, benefit provision or specific criterion  
 32 used as it related to the member's condition relied upon in making the  
 33 determination; or
  - 34 ○ A statement that such rule, guideline, protocol, benefit provision, or other  
 35 similar criterion was relied upon in making the determination and a statement  
 36 that a copy of such will be provided to the Member, upon request and free of  
 37 charge by contacting the Customer Service Department at (800) 678-9133 or  
 38 on-line [www.ashlink.com](http://www.ashlink.com);
- 39 • A notice regarding the availability of language assistance; and
- 40 • Notification that the Member is entitled to receive, upon request and free of charge,  
 41 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 member’s medical circumstances if the adverse benefit
- 4 determination is based on the medical necessity or experimental treatment or
- 5 similar exclusion or limitation;
- 6 • The reason for upholding the appeal decision in language that is specific to the
- 7 member’s condition;
- 8 • Language that is easy to understand, so the Member understands why ASH upheld
- 9 the appeal decision and has enough information to file the next appeal;
- 10 • A description of the Member’s further appeal rights;
- 11 • A statement that Members are not responsible for any charges or fees associated
- 12 with independent dispute resolution options, unless state law mandates that
- 13 members pay an IRO filing fee or the member is in a self-funded plan;
- 14 • Information regarding the availability of, and contact information for, any
- 15 applicable office of health insurance consumer assistance or ombudsman to assist
- 16 members with the appeals and independent review processes;
- 17 • Information regarding the availability of diagnosis and treatment codes and
- 18 descriptions; and
- 19 • As applicable, additional member health information.

20  
21 **Independent Levels of Review**

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

27  
28 **II. INDEPENDENT LEVELS OF REVIEW**

29  
30 **Medical Necessity Appeals**

31 The member has the right to appeal the decision of the review to the Commissioner of  
32 Insurance or Director, Arkansas Insurance Department, Consumer Services, 1 Commerce  
33 Way, Suite 102, Little Rock AR 72202, (501) 371-2640 or (800) 852-5464.

34  
35 **Overview**

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

39  
40 For treatment/services totaling \$500 or more, the appeal is reviewed by an Arkansas-  
41 approved independent and impartial, accredited Independent Review Organization (IRO).  
42 For treatment/services totaling less than \$500, the appeal is reviewed by an accredited IRO

1 contracted with ASH. The IRO reviewer shall have no ownership, control or professional,  
2 familial or financial conflicts of interest with ASH or the parties involved in the appeal that  
3 would influence the outcome of the case. For eligible appeals, ASH will send the contact  
4 information for the IRO and the independent review rights and processes to the Member.

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

9  
10 Throughout the review, the IRO considers all previously determined facts, allows the  
11 introduction of new information, considers and assesses sound medical evidence, and  
12 makes a decision that is not bound by the decision or conclusions of the internal appeal.  
13 ASH does not attempt to interfere with the IRO’s proceedings or appeal decision.

14  
15 The Member is not responsible for any charges or fees associated with independent dispute  
16 resolution options, unless state law mandates that members pay an IRO filing fee or the  
17 member is in a self-funded plan.

18  
19 The independent review decision is binding on ASH and the member except to the extent  
20 that other remedies are available under state and federal law. Binding decisions will not  
21 stop ASH from making payments on claims or providing benefits at any time, including  
22 after a final independent review decision that denies the claim or otherwise fails to require  
23 such payment or benefits. ASH must provide benefits pursuant to the final independent  
24 review decision without delay, regardless of whether ASH intends to seek judicial review  
25 of the independent review decision.

26  
27 ASH maintains or obtains data from the IRO on each appeal case and uses this information  
28 in evaluating the medical necessity decision-making process.

29  
30 **Submission Timelines**

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

38  
39 For treatment/services totaling \$500 or more, a Member may submit a written or electronic  
40 request for an external review to ASH. If a Member disagrees with an appeal decision,  
41 he/she may file a request for a voluntary level of review within sixty (60) calendar days of  
42 the date of the adverse appeal determination letter.

1 **Resolution and Notification Timelines**

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

6  
7 **Notification of the IRO Decision**

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

10  
11 The notification letter includes the following information:

- 12 • Resolution of the issue;
- 13 • List of titles and qualifications of participants in the appeal review;
- 14 • Notification that the Member is entitled to receive, upon request, reasonable access  
15 to and copies of documents relevant to the appeal; and
- 16 • The timeframe specified by the IRO within which ASH will implement the IRO  
17 decision.

18  
19 Notification of an adverse appeal decision will also include the following:

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

24  
25 **Right to Arbitration**

26 If the Member is not satisfied with the determination of the appeal after the IRO review,  
27 the Member may initiate an independent level of appeal consisting of arbitration through  
28 the National Arbitration Forum (the Forum). To obtain more information about the Forum,  
29 log on to The Forum’s official website at [www.arb-forum.com](http://www.arb-forum.com) or call the Forum at (800)  
30 474-2371. The Forum’s arbitration determination will be binding.

31  
32 **Right to Civil Action**

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

36  
37 **III. COVERAGE DISPUTES/  
38 ADMINISTRATIVE APPEALS**

39  
40 **Overview**

41 ASH will provide reasonable opportunity to Members for a full and fair review of an  
42 adverse benefit determination by offering two (2) levels of appeal. Members are given the

1 opportunity to submit for review written comments, documents, records, and other  
 2 information relating to their appeal request. This documentation, received in support of the  
 3 appeal, will be reviewed as part of the appeal, whether or not such documentation was  
 4 considered at the time of the initial determination.

5  
 6 Individuals who were not involved in any previous decisions and who are not subordinates  
 7 of any such individual participate in the appeal determination process.

### 9 **Submission Timelines**

10 A Member may submit written or verbal appeals. If a Member disagrees with an initial  
 11 adverse benefit determination, the Member may file an initial appeal within 180 days of  
 12 receiving notification of the adverse benefit determination.

### 14 **Notification Acknowledging Receipt of the Appeal**

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

### 22 **Resolution and Notification Timelines**

23 ASH resolves and notifies the Member of the determination at each level of a pre-service  
 24 appeal within 15 calendar days from the receipt of the appeal. ASH resolves and notifies  
 25 the Member of the determination at each level of a post-service appeal within 30 calendar  
 26 days from the receipt of the appeal.

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. ASH makes decisions on appeals based on all information  
 30 provided by the Member within the allowed timeframes, along with all information  
 31 previously submitted related to the case.

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

### 36 **Reviewers**

37 1<sup>st</sup> Level: A minimum of two (2) operational managers will review the appeal and make a  
 38 determination.

39 2<sup>nd</sup> Level: The Administrative Review Committee (ARC) will review the appeal and make  
 40 the final determination at this level.

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

3  
4 **Notification of Appeal Resolution**

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

- 7 • Resolution of the issue;
- 8 • List of titles, qualifications and the specialty of participants in the appeal review;
- 9 • Upon request, the name(s) of the reviewer(s);
- 10 • A notice regarding the availability of language assistance; and
- 11 • Notification that the member is entitled to receive, upon request, reasonable access  
12 to and copies of documents relevant to the appeal.

13  
14 Notification of an adverse appeal decision will also include the following:

- 15 • A clear and concise explanation in culturally and linguistically appropriate  
16 language of reasons for the determination;
- 17 • 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 Member, upon request and free of  
23 charge by contacting the Customer Service Department at (800) 678-9133 or  
24 on-line at [www.ashlink.com](http://www.ashlink.com).
- 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.

27  
28 **Voluntary Levels of Review**

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

33  
34 **IV. VOLUNTARY LEVELS OF REVIEW**

35  
36 **Coverage Disputes/Administrative Appeals**

37 **Overview**

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

1 **Submission Timelines**

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

5  
6 **Resolution and Notification Timelines**

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

9  
10 **Reviewers**

11 The voluntary level of review will be conducted by ASH’s Executive Review Committee  
12 (ERC). This committee consists of the Chief Operations Officer, Clinical Network  
13 Programs (COO), Senior Vice President, Specialty Network Operations, and a credentialed  
14 practitioner.

15  
16 **Notification of the ERC Decision**

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

18 The notification letter includes the following information:

- 19 • Resolution of the issue, which includes timeframes and procedures for a claim  
20 payment or approval of treatment/services in the event ERC overturns the decision;  
21 • List of titles and qualifications of participants in the appeal review.

22  
23 Notification of an adverse appeal decision will also include the following:

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

35  
36 **Right to Arbitration**

37 If the Member is not satisfied with the determination of the appeal after the ERC review,  
38 the Member may initiate a voluntary level of appeal consisting of arbitration through the  
39 National Arbitration Forum (the Forum). To obtain more information about the Forum, log  
40 on to The Forum’s official website at [www.arb-forum.com](http://www.arb-forum.com) or call the Forum at (800) 474-  
41 2371. The Forum’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 levels of review of the appeal have been completed  
4 and the appeal has not been approved.

5  
6 **V. MEMBER GRIEVANCES**

7  
8 **Quality of Care Grievances**

9 **Overview**

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

17  
18 The grievance reviewers consider any previous quality of care grievances against the  
19 provider or practitioner.

20  
21 **Submission Timeline**

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

24  
25 **Notification Acknowledging Receipt of the Grievance**

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

30  
31 **Resolution Timeline**

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

33  
34 **Reviewers**

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

1 **Notification of Grievance Resolution**

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

- 5 • Final resolution of the issue;
- 6 • A clear and concise explanation of reasons for the determination;
- 7 • A description of clinical criteria used, and the clinical rationale associated with the  
8 decision;
- 9 • A notice regarding the availability of language assistance; and
- 10 • A statement that Members retain the right to pursue all grievance and complaint  
11 mechanisms available through the applicable state or Federal regulatory agencies  
12 or as otherwise provided under law.

13  
14 **Quality of Service and Access to Care Grievances**

15 **Overview**

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

20  
21 A qualified individual will investigate the Member’s issue.

22  
23 **Submission Timeline**

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

27  
28 **Notification Acknowledging Receipt of the Grievance**

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

33  
34 **Resolution Timeline**

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

36  
37 **Reviewers**

38 The Appeals and Grievances department reviews the grievance and makes a final  
39 determination to resolve the issue.

1 **Notification of Grievance Resolution**

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

- 5 • Final resolution of the issue;
- 6 • A clear and concise explanation of reasons for the determination;
- 7 • A description of criteria used, and the rationale associated with the decision;
- 8 • A notice regarding the availability of language assistance; and
- 9 • A statement that Members retain the right to pursue all grievance and complaint  
10 mechanisms available through the applicable state and Federal regulatory agencies  
11 or as otherwise provided under law.

12  
13 **VI. RECORD KEEPING**

14  
15 ASH maintains records for each appeal and grievance that includes the following:

- 16 • The name of the member, provider and/or practitioner rendering service;
- 17 • Copies of all correspondence from the Member, provider and practitioner rendering  
18 service and ASH regarding the appeal and grievance;
- 19 • Dates of appeal and grievance reviews,
- 20 • Documentation of actions taken, including previous adverse determination and/or  
21 appeal history and follow up activities associated with adverse determinations and  
22 conducted before the current appeal,
- 23 • Final resolution; and
- 24 • The name and credentials of the peer clinical quality evaluator that reviewed the  
25 appeal, if applicable.

26  
27 Applicable meeting minutes are reviewed, signed by the chairperson, and maintained as  
28 record.