

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

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

6 **Product:** **Specialty**

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

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

18 **Definitions:**

19 ***Appeal -***

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

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

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

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

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

39 Additionally, with respect to group health plans, a declination for a benefit  
 40 resulting from the application of any medical necessity review, as well as a  
 41 failure to cover an item or service for which benefits are otherwise provided

1 because it is determined to be experimental or investigational or not  
2 medically necessary or appropriate.

3  
4 If a provider or practitioner files an appeal on behalf of a member with the member’s  
5 written consent, the appeal process defined in the *ASH Member Appeals and Grievances*  
6 – *Arkansas (AR UM 4 – S)* policy will be followed.

7  
8 **Effect of Filing an Appeal or Grievance**

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

11  
12 **I. PROVIDER AND PRACTITIONER APPEALS**

13  
14 **Medical Necessity Appeals**

15 **Overview**

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

18  
19 At each level of appeal, providers and practitioners are given the opportunity to submit for  
20 review written comments, documents, records, and other information relating to their  
21 appeal request. ASH documents if a practitioner does not submit information related to the  
22 appeal within the submission timeframe. This documentation, received by ASH in support  
23 of the appeal, is reviewed as a component of the appeal, whether or not such documentation  
24 was considered at the time of the initial determination.

25  
26 When making an appeal decision of an adverse benefit determination with regard to  
27 whether a particular treatment, drug, or other item is experimental, investigational, or not  
28 medically necessary or appropriate, ASH will consult with a health care professional that  
29 has appropriate training and experience in the field of medicine involved in the medical  
30 judgment.

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

37  
38 If a provider or practitioner submits an appeal for services the member has already  
39 appealed, the provider or practitioner request will be dismissed and the member request  
40 will be processed. If the provider or practitioner has appealed, the member can still appeal  
41 but not vice versa, unless a provider or practitioner provides significant additional

1 information supporting the medical necessity that was not available at the time of the  
2 member’s appeal.

3  
4 During the review of an appeal, the reviewers will not give deference to the initial adverse  
5 determination when making their appeal determinations.

6  
7 ASH would continue to provide coverage and make payment for the currently approved  
8 ongoing course of treatment while an internal appeal is under review.

9  
10 **Submission Timelines**

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

14  
15 **Resolution and Notification Timelines**

16 ASH resolves and notifies the provider or practitioner of a pre-service appeal within 15  
17 calendar days from the receipt of the appeal. ASH resolves and notifies the provider or  
18 practitioner of a post-service appeal within 30 calendar days from the receipt of the appeal.

19  
20 In the case that an appeal decision overturns the initial adverse benefit determination, ASH  
21 will implement the decision.

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

27  
28 Documentation of the provider or practitioner appeal is maintained, including the complete  
29 investigation of the substance of the appeal and any aspects of clinical care involved.

30  
31 **Reviewers**

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

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

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

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

13  
 14 For each appeal, the reviewer will attest that he/she has the appropriate  
 15 licensure/certification/registration that typically manages the treatment/services under  
 16 review and the experience and knowledge to conduct the appeal review.

### 17 **Notification of Appeal Resolution**

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

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

35  
 36 Notification of an adverse appeal decision will also include the following:

- 37 • An explanation of the scientific or clinical judgment for the determination, applying  
 38 the terms of ASH to the medical circumstances if the adverse benefit determination  
 39 is based on the medical necessity or experimental treatment or similar exclusion or  
 40 limitation.
- 41 • A description of the provider or practitioner’s further appeal rights

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

### 6 **Independent Levels of Review**

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

### 13 **Medical Necessity Expedited Appeals**

#### 14 **Overview**

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

18  
19 Providers and practitioners are given the opportunity to submit written comments,  
20 documents, records, and other information relating to their appeal request. ASH documents  
21 if a practitioner does not submit information related to the appeal within the submission  
22 timeframe. This documentation, received in support of the appeal, will be reviewed as part  
23 of the appeal, whether or not such documentation was considered at the time of the initial  
24 determination. A post-service appeal is not handled as an expedited appeal and will be  
25 handled within the timelines established in the Provider and Practitioner Medical Necessity  
26 Appeals section of this policy.

27  
28 When making an appeal decision of an adverse benefit determination with regard to  
29 whether a particular treatment, drug, or other item is experimental, investigational, or not  
30 medically necessary or appropriate, ASH will consult with a healthcare professional that  
31 has appropriate training and experience in the field of medicine involved in the medical  
32 judgment.

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

39  
40 During the review of an appeal, the reviewers will not give deference to the initial adverse  
41 determination when making their appeal determinations.

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

3  
4 **Submission Timelines**

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

8  
9 **Resolution and Notification Timelines**

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

14  
15 The period of time within which an appeal determination is required to be made begins at  
16 the time an appeal is filed. ASH makes decisions on appeals based on all information  
17 provided by the provider or practitioner within the allowed timeframes, along with all  
18 information previously submitted related to the case.

19  
20 Documentation of the provider or practitioner appeal is maintained, including the complete  
21 investigation of the substance of the appeal and any aspects of clinical care involved.

22  
23 **Reviewers**

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

27  
28 For post-service appeals, if the clinical director or senior clinician makes a decision that is  
29 not in favor of the member, the appeal is automatically sent for review by a credentialed  
30 practitioner in the same/similar specialty . The appeal decision made by the credentialed  
31 practitioner is the final decision at this appeal level.

32  
33 For pre-service appeals, if the clinical director or senior clinician makes a decision that is  
34 not in favor of the member, the appeal is automatically sent for review by an Arkansas-  
35 licensed physician (MD/DO). The appeal decision made by the Arkansas-

36  
37 Physicians (MD/DO) and clinical quality evaluators are board certified, if applicable, by a  
38 specialty board approved by the American Board of Medical Specialties or the Advisory  
39 Board of Osteopathic Specialists. Clinical quality evaluators maintain an active,  
40 unrestricted license, certificate, or registration in their specialty in a state or territory of the  
41 United States. Unless expressly allowed by state or federal laws or regulations, clinical

1 quality evaluators are located in a state or territory of the United States when reviewing an  
2 appeal.

3  
4 For each appeal, the reviewer will attest that he/she has the appropriate  
5 licensure/certification/registration that typically manages the treatment/services under  
6 review and the experience and knowledge to conduct the appeal review.

### 7 8 **Notification of Appeal Resolution**

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

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

25  
26 Notification of an adverse appeal decision will also include the following:

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

32  
33 For pre-service appeals, the name, title, address, toll-free telephone number and telephone  
34 extension of the Arkansas licensed physician (MD/DO) responsible for making the adverse  
35 determination, along with a listing of each state in which the Arkansas-licensed physician  
36 (MD/DO) is licensed and the license number issued by each state.

### 37 38 **Independent Levels of Review**

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

1 review is available in the Independent Levels of Review, Medical Necessity Appeals  
2 section of this policy.

## 3 4 **II. INDEPENDENT LEVELS OF REVIEW**

### 5 6 **Medical Necessity Appeals**

#### 7 **Overview**

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

#### 10 11 **Independent Review Process**

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

#### 15 16 **Arbitration**

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

## 21 22 **III. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS**

### 23 24 **Overview**

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

32  
33 Individuals who were not involved in any previous decisions and who are not subordinates  
34 of any such individual participate in the appeal determination process.

### 35 36 **Submission Timelines**

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



1 **Resolution and Notification Timelines**

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

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

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

12  
13 **Reviewers**

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

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

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

21  
22 **Notification of Appeal Resolution**

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

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

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

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

39  
40 **Arbitration**

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

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

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

5  
6 **Overview**

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

10  
11 **Submission Timeline**

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

14  
15 **Resolution Timeline**

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

17  
18 **Reviewers**

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

21  
22 **Notification of Grievance Resolution**

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

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