

1 **Policy:** **Provider and Practitioner Appeals and Grievances –**
2 **New Jersey**

3
4 **Date of Implementation:** **July 9, 2003**

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

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

13
14 Provided that ASH is delegated to handle claims payment and/or medical necessity
15 (utilization management) appeals, a practitioner may appeal any non-payment of a claim
16 or any Medical Necessity/Benefit Determination.

17
18 The procedures that practitioners will follow when appeals are not delegated to ASH are
19 set forth in the applicable Practitioner Services Agreement.
20

21 **Definitions:**

22 ***Appeal -***

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

25
26 ***Medical Necessity*** - Any appeal resulting from the adverse benefit determination
27 of treatment/services relative to medical necessity.

28
29 ***Medical Necessity Expedited*** - An appeal that is resolved expeditiously if the
30 member’s health or ability to function could be seriously harmed by waiting
31 for a determination to be made under the normal Medical Necessity Appeal
32 Timeframe, or the practitioner indicates there is an urgent need for
33 continued care.
34

35 ***Grievance*** - A formal expression of dissatisfaction where ASH is not being requested to
36 review or overturn an ASH decision.
37

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

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

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

11 **Effect of Filing an Appeal or Grievance**

12 ASH will take no retaliatory actions against the provider or practitioner as a result of filing
13 an appeal or grievance.
14

15 **I. PROVIDER AND PRACTITIONER APPEALS**

16
17 **Medical Necessity Appeals**

18 **Overview**

19 ASH provides reasonable opportunity to providers and practitioners for a full and fair
20 review of an adverse benefit determination by offering two (2) stages of appeal.
21

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

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

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

41 If a provider or practitioner submits an appeal for services the member has already
42 appealed, the provider or practitioner request will be dismissed and the member request

1 will be processed. If the provider or practitioner has appealed, the member can still appeal
 2 but not vice versa, unless a provider or practitioner provides significant additional
 3 information supporting the medical necessity that was not available at the time of the
 4 member’s appeal.

5
 6 In the event that the practitioner initiates an appeal, the practitioner must notify the
 7 member. The practitioner provides additional notice to the member each time he/she
 8 continues the appeal to the next stage in the appeal process, including any appeal to an
 9 Independent Utilization Review Organization (IURO).

10
 11 During the review of an appeal, the reviewers will not give deference to the initial adverse
 12 determination when making their appeal determinations.

13
 14 ASH would continue to provide coverage and make payment for the currently approved
 15 ongoing course of treatment while an internal appeal is under review.

16
 17 **Submission Timelines**

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

21
 22 **Resolution and Notification Timelines**

23 ASH resolves the first stage of a standard appeal within ten (10) calendar days from the
 24 receipt of the appeal. ASH resolves the second stage of a standard appeal within 20 business
 25 days from the receipt of the appeal.

26
 27 In the case that a first or second stage appeal decision overturns the initial adverse benefit
 28 determination, ASH will implement the decision.

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

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

37
 38 **Reviewers**

39 1st Stage: ASH’s medical director or his/her designee reviews the appeal.

1 ASH will provide an opportunity for the Member to speak to ASH’s medical director or
 2 his/her designee who rendered the adverse benefit determination regarding an adverse
 3 service or 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 Physicians (MD/DO) and clinical quality evaluators are board certified, if applicable, by a
 18 specialty board approved by the American Board of Medical Specialties or the Advisory
 19 Board of Osteopathic Specialists. Clinical quality evaluators maintain an active,
 20 unrestricted license, certificate, or registration in their specialty in a state or territory of the
 21 United States. Unless expressly allowed by state or federal laws or regulations, clinical
 22 quality evaluators are located in a state or territory of the United States when reviewing an
 23 appeal.

24
 25 For each appeal, the reviewer will attest that he/she has the appropriate
 26 licensure/certification/registration that typically manages the treatment/services under
 27 review and the experience and knowledge to conduct the appeal review.

28
 29 **Notification of Appeal Resolution**

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

- 32 • Resolution of the issue;
- 33 • List of titles, qualifications and the specialty of participants in the appeal review;
- 34 • A clear and concise explanation in culturally and linguistically appropriate
 35 language of reasons for determination;
- 36 • Clinical rationale associated with the decision including the following:
 - 37 ○ The internal rule guideline, protocol, benefit provision or other similar criterion
 38 relied upon in making the determination; or
 - 39 ○ A statement that such rule, guideline, protocol, benefit provision, or other
 40 similar criterion was relied upon in making the determination and a statement
 41 that a copy of such will be provided to the practitioner, upon request and free

1 of charge by contacting the Customer Service Department at (800) 972-4226 or
 2 on-line at www.ashlink.com; and

- 3 • Notification that the provider or practitioner is entitled to receive, upon request and
 4 free of charge, reasonable access to and copies of documents relevant to the appeal.

5

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

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

14

15 **Independent Review**

16 If the provider or practitioner is not satisfied with the determination after the internal stages
 17 of appeal are completed, the provider or practitioner has the option to pursue an
 18 independent external review in accordance with the guidelines describe in the Independent
 19 Stages of Review, Medical Necessity Appeals section of this policy.

20

21 **Medical Necessity Expedited Appeals**

22 **Overview**

23 ASH provides reasonable opportunity to providers and practitioners for a full and fair
 24 review of a pre-service adverse benefit determination by offering two (2) stages of review
 25 for expedited appeals.

26

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

35

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

1 Individuals who were not involved in any previous decisions and who are not subordinates
2 of any such individual participate in the appeal determination process. In addition, a health
3 care professional engaged in the appeal process for purposes of a consultation will be an
4 individual who was not consulted in connection with the adverse benefit determination or
5 the subordinate of any such individual.

6
7 During the review of an appeal, the reviewers will not give deference to the initial adverse
8 determination when making their appeal determinations.

9
10 ASH would continue to provide coverage and make payment for the currently approved
11 ongoing course of treatment while an internal appeal is under review.

12
13 **Submission Timelines**

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

17
18 **Resolution and Notification Timelines**

19 ASH resolves and notifies the provider or practitioner verbally of the determination at each
20 stage of appeal as soon as possible, but no later than 72 hours from the receipt of the appeal.
21 Written confirmation of the notification is provided to the provider or practitioner within
22 three (3) calendar days from the receipt of the appeal.

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

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

31
32 **Reviewers**

33 1st Stage: ASH’s medical director or his/her designee reviews the appeal.

34
35 ASH will provide an opportunity for the Member to speak to ASH’s medical director or
36 his/her designee who rendered the adverse benefit determination regarding an adverse
37 service or benefits determination.

38
39 2nd Stage: A panel of practitioners including at least one (1) New Jersey licensed physician
40 selected by ASH who have not been involved in the adverse benefit determination at issue.
41 The Member has the right to be present to pursue his/her appeal before the panel. The
42 decision made by the panel is the final decision at this stage.

1 ASH will allow a contracted practitioner in the same/similar specialty of the treating
 2 practitioner to participate with the panel in the review of the case if so requested by the
 3 Member.

4
 5 In all cases, licensed physicians (MD/DO) adhere to established clinical criteria when
 6 reviewing appeals.

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

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

19
 20 **Notification of Appeal Resolution**

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

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

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

- 39 • An explanation of the scientific or clinical judgment for the determination, applying
 40 the terms of ASH to the medical circumstances if the adverse benefit determination
 41 is based on the medical necessity or experimental treatment or similar exclusion or
 42 limitation; and

- A description of the practitioner’s further appeal rights.

Independent Review

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

II. INDEPENDENT STAGES OF REVIEW

Medical Necessity Appeals

Overview

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

Independent Review Process

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

Arbitration

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

Medical Necessity Appeals

Overview

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

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

Independent Review Process

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

1 **Arbitration**

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

6
 7 **III. PRACTITIONER APPEALS**
 8 **Payment or Denial of a Claim**
 9

10 **Submission Timelines**

11 Practitioners may initiate an appeal on or before the 90th calendar day following receipt by
 12 the practitioner of ASH’s claims determination (or by the Health Plan in the case that ASH
 13 is not delegated to pay claims), which is the basis of the appeal, by submitting a fully
 14 completed DOBI form (available at
 15 <https://www.state.nj.us/dobi/chap352/352genapplication.doc>) together with all
 16 information and documentation requested by such form. If the practitioner does not file an
 17 appeal by submitting the Health Care Provider Application to Appeal a Claim
 18 Determination form to ASH within 90 days after the date of the determination of a claim,
 19 such appeal will not be considered by ASH. The member will not be billed for any charges
 20 for covered services not approved for payment due to late submission of the Health Care
 21 Provider Application to Appeal a Claim Determination form by the practitioner, and all
 22 such charges will be waived by the practitioner.

23
 24 **Reviewers**

25 A claims payment appeal is reviewed by ASH management staff not responsible for claims
 26 payment on a day-to-day basis, and is provided at no cost to the practitioner.

27
 28 **Timelines and Notification of Appeal Resolution**

29 A claims payment appeal is reviewed, and a written notification of the appeal decision is
 30 sent to the practitioner within 30 calendar days of receipt of the appeal. The notification of
 31 the appeal decision includes:

- 32 • The names, titles, and qualifying credentials of the persons participating in the
- 33 review;
- 34 • A re-statement of ASH’s understanding of the practitioner’s appeal;
- 35 • The decision of the reviewers and a detailed explanation of the basis for such
- 36 decision;
- 37 • A description of the evidence or documentation that supports the decision; and
- 38 • A description of how to request Arbitration if the final internal appeal decision by
- 39 ASH results in an adverse benefit determination.

40
 41 ASH will conduct a review of the appeal and notify the practitioner of its determination on
 42 or before the 30 calendar day following ASH’s receipt of the completed appeal form.

1 If the practitioner is not notified of ASH’s determination of the appeal within 30 days, the
2 practitioner may refer the dispute to arbitration.

3
4 If ASH determines through the internal appeal process that the practitioner’s claim should
5 be paid, ASH shall pay such claims with accrued interest at the rate of 12% per annum, on
6 or before the 30th calendar day following the notification of ASH’s determination on the
7 appeal.

8
9 Interest will begin to accrue on the day the appeal was received by ASH.

10
11 **Program for Independent Claims Payment Arbitration**

12 Either the practitioner (if they are not satisfied with the determination after the internal
13 stage of appeal is completed) or ASH may initiate an arbitration proceeding on or before
14 the 90th calendar day following receipt of the determination which is the basis of the appeal,
15 by submitting the DOBI form and all required information and documentation for
16 submission of a claim to the Program for Independent Claims Payment Arbitration
17 (PIPICA).

18
19 The State of New Jersey defines arbitration as any dispute regarding the determination of
20 an internal health plan appeal, not including medical necessity appeals. The practitioner
21 may initiate arbitration on or before the 90th calendar day following receipt of the initial
22 health plan claim determination which is the basis of the appeal, on a form prescribed by
23 the New Jersey Commissioner of Banking and Insurance. No dispute will be accepted for
24 arbitration unless the payment amount in dispute is \$1,000 or more, except that the
25 practitioner may aggregate disputed claim amounts for the purpose of meeting the
26 threshold requirements.

27
28 To initiate arbitration, a practitioner is required to complete an application, accessible
29 online at <https://njpica.maximus.com/>, and submit the application with the required
30 review and arbitration fees. Applications are submitted online. A case number is generated
31 through the online submission process. If a practitioner wishes to submit their application
32 by mail, they must contact the arbitration company using the contact information at
33 <https://njpica.maximus.com/>.

34
35 Supporting documentation may be submitted online, via fax or mail and must include the
36 case number. Fees must be submitted by mail and include the case number. An application
37 for arbitration will not be considered until the required application fees are received.

38
39 Both a practitioner requesting arbitration and ASH are required to pay a review fee and an
40 arbitration fee. A practitioner must submit his/her fees with the arbitration application. If
41 the application initially meets the criteria for acceptance, the arbitration organization will
42 notify ASH of the action and of the fee requirements. If based on information received by

1 ASH the arbitration company ultimately determines that the case does not meet the criteria
2 for arbitration, the arbitration organization will return the arbitration fees to both parties
3 but will retain the review fees.

4
5 For a single claim in which the dispute is at least \$1,000, the arbitration organization
6 requires each party to pay a \$50 review fee and a \$130 arbitration fee. For aggregated
7 claims in which the disputed amount for each individual claims is less than \$1,000, an
8 additional \$50 review fee and \$130 arbitration fee will be assessed for every \$1,000 worth
9 of disputed claim amounts. For aggregated claims in which the disputed amount for each
10 individual claims exceeds \$1,000, fees will be assessed based on the number of individual
11 claims rather than their dollar amount (e.g., five aggregated claims would be assessed five
12 review and five arbitration fees).

13
14 The arbitrator conducts the arbitration proceedings pursuant to the rules of the arbitration
15 entity, including rules of discovery subject to confidentiality requirements established by
16 State or Federal law.

17
18 An arbitrator’s determination will be:

- 19 • Signed by the arbitrator;
- 20 • Issued in writing on a form prescribed by the Commissioner of Banking and
21 Insurance, and will include a statement of the issues in dispute and the findings and
22 conclusions on which the determination is based; and
- 23 • Issued on or before the 30th calendar day following the receipt of the required
24 documentation.

25
26 The arbitrator will resolve the dispute within 30 calendar days of receiving all necessary
27 information from the practitioner.

28
29 If an arbitrator determines that ASH has wrongfully withheld or denied payment, ASH will
30 pay the claim, together with accrued interest at 12% per annum (if ordered by the
31 arbitrator), calculated from the date that ASH’s payment was due (the date 30 days
32 following electronic submission of the claim, or 40 days following a paper submission) on
33 or before the 10th business day following the issuance of the determination.

34
35 The arbitration determination cannot be appealed and will be binding on all parties to the
36 dispute.

37
38 If the arbitrator determines that ASH has withheld or denied payment in violation of the
39 provisions of Sections NJSA 26:2J-8.1 or NJSA 17B:27-44.2, the arbitrator will order ASH
40 to make payment of the claims, together with accrued interest, on or before the 10th business
41 day following the issuance of the determination. If the arbitrator determines that ASH has
42 withheld or denied payment on the basis of information submitted by the practitioner and

1 ASH requested but did not receive this information from the practitioner when the claim
2 was initially processed or reviewed under internal appeal pursuant to the provisions of
3 Sections NJSA 26:2J-8.1 or NJSA 17B:27-44.2, ASH will not be required to pay any
4 accrued interest.

5
6 If the arbitrator determines that a practitioner has engaged in a pattern and practice of
7 improper billing and a refund is due to ASH, the arbitrator may award ASH a refund
8 including accrued interest.

9
10 The arbitrator will file a copy of each determination with and in the form prescribed by
11 the New Jersey Commissioner of Banking and Insurance.

12
13 **IV. COVERAGE DISPUTES/ADMINISTRATIVE APPEALS**
14 **Not related to Payment or Denial of a Claim**

15
16 **Overview**

17 ASH provides reasonable opportunity to providers or practitioners for a full and fair review
18 of an adverse benefit determination by offering three (3) stages of appeal. At each stage of
19 appeal, provider or practitioners are given the opportunity to submit for review written
20 comments, documents, records, and other information relating to their appeal request. This
21 documentation, received by ASH in support of the appeal, is reviewed as a component of
22 the appeal, whether or not such documentation was considered at the time of the initial
23 determination.

24
25 Individuals who were not involved in any previous decisions and who are not subordinates
26 of any such individual participate in the appeal determination process.

27
28 **Submission Timelines**

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

32
33 **Resolution and Notification Timelines**

34 ASH resolves and notifies the provider or practitioner of each stage of an administrative
35 appeal within 30 calendar days from the receipt of the appeal.

36
37 The period of time within which an appeal determination is required to be made begins at
38 the time an appeal is filed with ASH. ASH makes decisions on appeals based on all
39 information provided by the provider or practitioner within the allowed timeframes, along
40 with all information previously submitted related to the case.

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

3
 4 **Reviewers**

5 1st Stage: A minimum of two (2) operational managers reviews the appeal and makes an
 6 appeal determination.

7 2nd Stage: The Administrative Review Committee (ARC) reviews the appeal and makes
 8 an appeal determination.

9 3rd Stage 1: The Executive Review Committee (ERC) reviews the appeal and makes an
 10 appeal determination. The appeal decision made by the ERC is the final decision at this
 11 appeal stage.

12
 13 **Notification of Appeal Resolution**

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

- 16 • Resolution of the issue;
- 17 • List of titles, qualifications and the specialty of participants in the appeal review;
 18 and
- 19 • Notification that the provider or practitioner is entitled to receive, upon request,
 20 reasonable access to and copies of documents relevant to the appeal.

21
 22 Notification of an adverse appeal decision will also include the following:

- 23 • A clear and concise explanation in easily understandable language of reasons for
 24 the determination;
- 25 • 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 description of the provider or practitioner’s further appeal rights which includes
 29 arbitration, if applicable.

30
 31 **Arbitration**

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

36
 37 **V. PROVIDER AND PRACTITIONER GRIEVANCES**

38
 39 **Overview**

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

1 **Submission Timeline**

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

4
5 **Resolution Timeline**

6 Grievances are resolved within 30 calendar days from the receipt of the grievance.
7

8 **Reviewers**

9 The Appeals and Grievances Department researches and reviews the case, and if
10 applicable, contacts the provider or practitioner in an effort to resolve the grievance.
11

12 **Notification of Grievance Resolution**

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

- 15
- 16 • A summary of the grievance;
 - 17 • Resolution of each issue, including a clear and concise explanation of reasons for
determination; and
 - 18 • Notification that the provider or practitioner may have a right to file their grievance
19 in accordance with their state’s grievance procedures, if available.