Arkansas Blue Cross and Blue Shield

Network Participation Appeal Policy and Procedures

APPEALS FROM NETWORK PARTICIPATION
OR
CREDENTIALING DECISIONS

Eligible applicants and participating practitioners who dispute a network participation or credentialing decision of Arkansas Blue Cross and Blue Shield's Credentialing or Chiropractic Committee or Arkansas Blue Cross and Blue Shield's management may appeal the decision in accordance with the appeals procedures outlined herein, subject to the limitations on the scope and availability of such appeal procedures as described in this policy.

I. APPEALS COMMITTEE - FIRST-LEVEL APPEALS

All practitioner appeals shall be directed to and resolved by an appeals process designated or approved for such purpose by the management of Arkansas Blue Cross and Blue Shield (ABCBS). ABCBS reserves the right to determine in its sole discretion the membership and qualifications of any Appeals Committees designated or approved by its management.

The membership of the Appeals Committees, and the qualifications for its members, may be changed at any time without notice or formal action, at the sole discretion of ABCBS.

A. Initiation of Appeal Process

Should a practitioner dispute a network participation decision of the Credentialing or Chiropractic Committee or ABCBS, he or she must appeal the decision in writing prior to taking any other action.

To initiate an appeal, the practitioner must, **within 14 calendar days** after a Credentialing or Chiropractic Committee or other network participation decision was post-marked for mailing to the practitioner, deliver to the Provider Network Operations Manager written notice of the practitioner's request for an appeal.

If no valid request for an appeal is received by the Provider Network Operations Manager within 14 calendar days after the Credentialing, or Chiropractic Committee's, or ABCBS's decision was post-marked for mailing, the practitioner may not thereafter request and shall not be entitled to an appeal.

NOTE: Failure to deliver a valid request for appeal within the 14 days allotted shall constitute waiver by the practitioner of any right

to appeal, as well as waiver of all objections to the decision of the Credentialing or Chiropractic Committee or ABCBS.

B. Conduct of Appeal Proceedings

Upon receipt of a valid appeal request from an affected practitioner the appeal request will be referred to the Appeals Committee for review. The provider will be notified in writing that his or her appeal will be considered by the Appeals Committee and will be subsequently notified of their decision. The Appeals Committee will include as voting members:

- Corporate Medical Director External Affairs,
- Health Advantage Associate Medical Director
- Director Provider Network Operations,
- A network-participating physician (M.D. or D.O.)

Advisory staff of the Appeals Committee will include:

- Senior Counsel, Litigation
- Provider Network Operations Manager

The Appeals Committee will determine whether additional records or information are necessary or would be helpful in resolving the appeal, and may, in the sole discretion of the Appeals Committee, exercise any of the options outlined herein.

No practitioner shall have a right to personally appear before the Appeals Committee, but in all cases the affected practitioner will be afforded an opportunity to present his or her position, including information he or she deems relevant, to the Appeals Committee, either in writing or, upon invitation of the Appeals Committee in its sole discretion, in person.

Failure of an affected practitioner to cooperate with the Appeals Committee in the appeals review or failure to furnish with reasonable promptness any requested documents or information, alone shall constitute sufficient grounds, for exclusion or termination of the affected practitioner from the network(s), or for implementation of any option outlined herein.

The Appeals Committee's options may include, but are not limited to, any of the following:

- exclusion or termination from network participation;
- restriction, limitation or suspension of network participation;
- letters of reprimand or warning;
- 100% review of all reimbursement claims;
- random or focused chart audits;
- site visit requirements;
- provisional or probationary network participation;

- other actions deemed appropriate in the sole discretion of the Appeals Committee.

After completion of its review, the Appeals Committee shall send to the affected practitioner, a letter setting forth the Appeals Committee decision. Any practitioner who wishes to dispute an adverse decision of the Appeals Committee may pursue a second level appeal with the Executive Review Appeals Committee, as hereinafter provided.

C. First Level Appeal Process Timeline*

a. Notice of adverse network participation decision posted to practitioner.
b. Practitioner has 14 days* from the adverse decision notice post-mark date to submit a written notice appealing the decision. *Note: this deadline is merely to submit a written notice of appeal; if needed/requested, appealing practitioners are commonly granted extensions of time in which to submit a full appeal or complete materials, and such extensions will ordinarily be granted for up to 30 days, and, in exceptional cases where justified, may be granted for additional time, not to exceed 90 days.
c. In most cases*, written appeals submitted timely will cause the network termination process to be suspended pending completion of the appeal process and issuance of a final appeal decision. Acceptance of appeals received after the 14 day deadline will be at the discretion of the Appeals Committee Chairperson. Late appeals will not suspend the termination process. If a late appeal is accepted for review and approved a gap in network participation may result. *Note: in cases involving concern for member health and safety, or in cases involving suspected fraud or abusive billing practices, the Networks reserve the right to make a termination effective immediately upon notification to the practitioner.
d. First level appeals will ordinarily be presented to the Appeals Committee for review within 45 days of receipt of a timely and complete appeal. If for any reason the Appeals Committee is unable to meet and review pending appeals within 45 days a courtesy notice of the delay will be sent to the practitioner. Note: if the appealing practitioner requests or receives an extension of time in which to submit appeal materials, any such extension will also extend the time period for submission to the Appeals Committee.
e. Notice of the Appeals Committee's decision will ordinarily* be posted to the practitioner within 30 days of the Appeals Committee meeting at which a final Committee vote is taken with respect to the appeal. *Note: If circumstances arise that render it difficult or impossible to release a final determination notice within 30 days, the appealing practitioner will be notified of the delay; in all events, notice

of the Appeals Committee's decision will be issued not later than 60 days following the meeting at which a final Committee vote is taken with respect to the appeal.

f. Approval of the first level appeal ends the appeal process.

*Date spans are counted as calendar days

II. CONDUCT OF EXECUTIVE APPEAL PROCEEDINGS (SECOND-LEVEL APPEAL)

A. Initiating Second-Level Appeal

Practitioners who wish to dispute an adverse decision of the Appeals Committee, may do so by submitting a written second-level appeal request to the Executive Review Appeals Committee (ERAC). All such second-level appeal requests must be submitted to the ERAC via delivery to the Provider Network Operations Manager (as further specified below), who will forward the same to the ERAC.

Any request for a second-level appeal to ERAC must be received by the Provider Network Operations Manager **within 14 calendar days** after the Appeals Committee's decision was post-marked for mailing to the practitioner.

If no valid request for a second-level appeal is received by the Provider Network Operations Manager within 14 calendar days after the Appeals Committee's decision was post-marked for mailing, the practitioner may not thereafter request and shall not be entitled to a second-level appeal.

NOTE: Failure to deliver a valid request for second-level appeal within the 14 days allotted shall constitute waiver by the practitioner of any right to second-level appeal, as well as waiver of all objections to the decision of the Credentialing or Chiropractic Committee or ABCBS.

B. Conduct of Second-Level Appeal Proceedings

The ERAC will include as voting members:

- Senior Vice President Law and Governmental Relations and Chief Legal Officer (Chair)
- Senior Vice President and Chief Medical Officer
- Corporate Medical Director, Internal Affairs
- President and CEO, Health Advantage
- Senior Vice President Enterprise Networks
- A network-participating physician (M.D. or D.O.) who did not participate in the first-level appeal decision.

Advisory staff of the ERAC will include:

- Senior Counsel, Litigation
- Senior Counsel, Legal: Regulatory
- Provider Network Operations Manager

The ERAC will determine whether additional records or information are necessary or would be helpful in resolving the second level appeal, and may, in its sole discretion, exercise any of the options outlined herein.

No practitioner shall have a right to personally appear before the ERAC, but in all cases the affected practitioner will be afforded an opportunity to present his or her position, including information he or she deems relevant, to the ERAC, either in writing or, upon invitation of the ERAC in its sole discretion, in person.

Failure of an affected practitioner to cooperate with the ERAC in the second level appeal review or failure to furnish with reasonable promptness any requested documents or information, alone shall constitute sufficient grounds, for exclusion or termination of the affected practitioner from the network(s), or for implementation of any option outlined herein.

The Executive Review Appeals Committee's options may include but are not limited to any of the following:

- Upholding the decision of the Appeals Committee in whole or in part, or as modified in ERAC's discretion;
- restriction, limitation or suspension of network participation;
- letters of reprimand or warning;
- 100% review of all reimbursement claims;
- random or focused chart audits;
- site visit requirements;
- provisional or probationary network participation;
- other actions deemed appropriate in the sole discretion of ERAC.

After completion of the second level appeal review, the ERAC (acting via the Provider Network Operations Manager) shall send to the affected practitioner, a letter setting forth the Executive Review Appeals Committee's decision. Decisions of the ERAC are final and conclude the network appeal process.

C. Second Level Appeal Process TimeLine*

a. Notice of first level appeal adverse decision is ordinarily* posted to practitioner within 30 days of the Appeals Committee meeting at which a final Committee vote is

taken with respect to the appeal. *Note: If circumstances arise that render it difficult or impossible to release a final determination notice within 30 days, the appealing practitioner will be notified of the delay; in all events, notice of the Appeals Committee's decision will be issued not later than 60 days following the meeting at which a final Committee vote is taken with respect to the appeal.

b. Practitioner has 14 days* from the post-mark date of the first level appeal adverse decision notice to submit a written notice requesting a second and final appeal. In most cases**, receipt of a timely second level appeal will continue the hold on the network termination process. Acceptance of a late second level appeal will be at the discretion of the ERAC Chairperson.

*Note: this deadline is merely to submit a written notice of second level appeal; if needed/requested, appealing practitioners are commonly granted extensions of time in which to submit a full appeal or complete materials, and such extensions will ordinarily be granted for up to 30 days, and, in exceptional cases where justified, may be granted for additional time, not to exceed 90 days.

**Note: in cases involving concern for member health and safety or in cases involving suspected fraud or abusive billing practices, should anything arising in the course of the second level appeal process raise such concerns, the Networks reserve the right to make a termination effective immediately upon notification to the practitioner of the outcome of the first appeal level appeal.

c. ERAC will review all pending second level appeals within 45 days of receipt of a timely second level appeal. If for any reason ERAC is unable to meet and review pending second level appeals within 45 days of receipt a courtesy notice of the delay will be sent to the practitioner. Note: if the appealing practitioner requests or receives an extension of time in which to submit appeal materials, any such extension will also extend the time period for submission to the Appeals Committee.

d. Notice of ERAC's decision will ordinarily* be posted to the practitioner within 30 days of the Appeals Committee meeting at which a final Committee vote is taken with respect to the appeal. *Note: If circumstances arise that render it difficult or impossible to release a final determination notice within 30 days, the appealing practitioner will be notified of the delay; in all events, notice of ERAC's decision will be issued not later than 60 days following the meeting at which a final ERAC vote is taken with respect to the appeal.

e. ERAC's decision ends the appeal process.

*Date spans are counted as calendar days

NOTE: Appeal denials related to quality of care or clinical competency issues will be reported to the National Practitioner Data Bank.

III. POLICY REVIEW

The Network Participation Appeal Policy and Procedures are reviewed, revised (if and to the extent appropriate), and approved annually by the Credentialing Committee. Components of the policy and procedures, including the need to be expanded, revised or deleted, are identified and addressed to assure the ongoing, comprehensive and effective functioning of the Network Participation Appeal Policy and Procedures.

Policies and procedures supporting the Network Participation Appeal process are reviewed and approved at least annually by the Director of Provider Network Operations and Regional Medical Director Committee (RMD).