Network Participation Appeal Policy and Procedures

Arkansas Blue Cross and Blue Shield

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

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/entity or their legal counsel 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/entity or their legal counsel 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/entity 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.) not employed by or otherwise affiliated with ABCBS or its affiliates
- An ABCBS vice president responsible for provider networks

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.

In all cases the affected practitioner/entity will be afforded an opportunity to present his or her position, including information he or she deems relevant, to the Appeals Committee, both in writing and, if requested in writing at least 60 days in advance of any regularly-scheduled Appeals Committee hearing, in a virtual in-person statement to the Appeals Committee. In person appeal statements to the Appeals Committee will be limited to 20 minutes, in which a practitioner/entity or their legal counsel, (but not both), will be afforded the opportunity to present the practitioner's case to the Appeals Committee. Practitioners and their legal counsel who elect to request an in-person statement to the Appeals Committee are subject to questions from any voting member of the Appeals Committee. If questions are asked, the 20 minutes allotted for an in-person appeal statement will be extended, upon request, by the time consumed by any such questions. Practitioners and their legal counsel who elect to request an in-person statement to the Appeals Committee may not question the Appeals Committee or Network staff during any such appearance; all questions directed to the Networks or the Appeals Committee must be submitted in writing. Following completion of any requested in-person statement to the Appeals Committee, practitioners and their legal counsel must leave the meeting so that Appeals Committee deliberations can proceed in private.

Please Note: The Networks expect that most appeals will proceed and be conducted and decided based solely on the written materials submitted in support of a practitioner's appeal. Accordingly, all regularly-scheduled meetings of the Appeals Committee are reserved for discussion and resolution of pending written appeals, i.e., those in which no in-person appearance/hearing has been requested. This means that if/when a practitioner requests an in-person hearing, it will be necessary for the Networks to schedule a special meeting of the Appeals Committee. This is the reason for requiring a minimum 60-day notice from any practitioner who seeks to invoke the right to an in-person hearing. While the Networks hope to schedule and conduct such in-person hearings approximately 60-90 days after request, when practicable, practitioners are hereby warned that it may not be possible to do so because of scheduling issues/conflicts of Appeals Committee and/or Network staff members and the necessity to keep regularly-scheduled Appeals Committee meetings on track. Accordingly, practitioners who are considering requesting in-person hearing should be aware that doing so may result in significant delays in conducting and concluding the appeals process.

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.

C. 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. Written appeals (those not involving any request for in-person appearance) 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 written appeals within 45 days, a courtesy notice of the delay will be sent to the practitioner. As noted above, request for an in-person hearing may significantly delay resolution of the appeal because a special meeting date must be scheduled with the

Appeals Committee; accordingly, in-person hearings normally will not occur sooner than 60-90 days after submission of the appeal, and could be significantly longer, depending on special scheduling logistics.

Note: if the appealing practitioner requests and 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 60 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 60 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 90 days following the meeting at which a final Committee vote is taken with respect to the appeal.

f. The decision of the Appeals Committee ends the appeal process.

*Date spans are counted as calendar days

After all dispute options have been exhausted, providers who are deemed ineligible for Network participation will be routed back to Provider Network Operations Manager or QA Analyst to ensure that they are not listed in the provider directories.

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

II. 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.