15 Claim Disputes, Member Appeals, and Member Grievances

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Definitions:

Claim Dispute – As defined in A.A.C.R9-34-402 (B) means, "a dispute involving a payment of claim, denial of claim, imposition of a sanction or reinsurance".

Member Appeal – the request for review of an action (see definition of "Action")
Action – The definition of action [per 42 CFR 438.400(b)] is the:

1. **Denial or limited authorization of a requested service, including the type or level of service;**
2. **Reduction, suspension, or termination of a previously authorized service;**
3. **Denial, in whole or in part, of payment for a service;**
4. **Failure to provide services in a timely manner;**
5. **Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or**
6. **Denial of a rural member's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.**

Member Grievance – dissatisfaction with any aspect of their care (other than the appeal of actions).

ALTERNATIVE TO FILING A DISPUTE (FIRST STEPS TO CONSIDER BEFORE FILING A DISPUTE)

Claim Resubmissions

If your claim has denied for additional information or corrections, it is considered a *Resubmission (i.e. missing medical records, an IZ form, not a clean claim, etc.).* Claim resubmissions should be sent back to the plan for reconsideration with a stamp or legible notice that the claim is a "Resubmission". If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim.
Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the correct claim form with the services listed in detail.

All claim resubmissions can be mailed to

Health Choice
Arizona
Attn: Claims Department - Resubmissions
410 N. 44th St., Ste 500
Phoenix, AZ 85008

All Providers have the right to file a claim dispute in response to any adverse action or decision made by Health Choice Arizona. However, Health Choice Arizona encourages Providers to exhaust all other means of resolution before using the claim dispute process. See options below:

Claims status options:

- ☐ **Provider portal**. The provider portal offers many features including claims status checks, EOB, member eligibility inquiry and member rosters. This tool puts the control in the provider's hands and allows staff the opportunity to status claims on their time without waiting on hold.

  Claims Customer Service. The Claims Customer Service line is a group of dedicated personnel trained to answer questions about claims and status claims for the provider. Providers may contact Health Choice Arizona Claims Resolution Services Unit at (800) 322-8670 to resolve claims reimbursement issues informally. The Claims Resolution Services Unit provides assistance with claim issues including denied claims and incorrectly paid claims. Providers and office staff may also contact Claims Resolution Services to discuss questions about a remittance advice and/or to check the status of a claim.

- ☐ **Electronic EOB (835)**. The electronic EOB or electronic remittance advice (sometimes referred to as the ERA or 835) is a more automated way of posting payments from the EOB that can be directly inputted into your practice management system. Contact your clearinghouse or practice management software vendor to see if you have this capability.

CLAIM DISPUTE AND STATE FAIR HEARING PROCESS (FOR PROVIDERS)

Health Choice Arizona processes provider Claim Disputes and State Fair Hearings in accordance with established law, rules, and procedures set forth by AHCCCS (ARS §36-2903.01 and AAC R9-34-401 et seq. Disputes are handled in the Disputes Department in Compliance.

FILING A CLAIM DISPUTE

If you disagree with a decision made on your claim, you can file a Claim Dispute. Per AHCCCS rules, claim disputes challenging claim denials must be filed no later than twelve (12) months from the date of service, twelve (12) months from the date of eligibility posting or within sixty (60) days after the date of denial of a timely claim submission, whichever is later.

Untimely disputes will be denied as untimely and Health Choice Arizona will not address the merits of the dispute.

For timeliness of claim disputes, please note that per ARS 36-2904.G.3 "Submitted" means the date the **claim** is **received** by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt. This means that you must provide proof that Health Choice received your claim such as a tracking number or certified mailing card.

Please submit the following documentation with the written claim dispute:

☐ **Cover letter for each member's claim being disputed must be provided, stating the problem and the relief requested:**

1. **Name of the person filing the dispute and that person's phone number**
2. **Provider fax number - where Health Choice Arizona should send the decision letter**
3. **Copy of the claim (including EOB's from any primary payors, if applicable) and claim number**
4. **Copies of all supporting documentation, which may include, but is not limited to:**
   - ☐ **Medical records to support your argument**
   - ☐ **Documentation of phone calls or other correspondence to support your argument**
   - ☐ **Documentation of reference materials (such as policies, medical standards, or coding information) to support your argument**

You may fax claim disputes to (855)-500-2318. If you are unable to send a Claim Dispute via fax, you may mail it to:

Health Choice Arizona
Attention: Claim Dispute Department
410 N. 44th St., Ste 900
Phoenix, AZ 85008

Once Health Choice Arizona receives the dispute, Health Choice Arizona will send you an acknowledgment letter by regular mail within 5 working days. Health Choice Arizona will issue a decision on all claim disputes within thirty (30) days from the date that the Health Plan received the claim dispute. If an extension is necessary, Health Choice Arizona will notify the Provider. If the claims dispute is overturned (approved), Health Choice Arizona will reprocess the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

FILING A REQUEST FOR STATE FAIR HEARING

If you are not satisfied with the claim dispute decision, you may submit for a *Request for State Fair Hearing*. The Request for State Fair Hearing must be received by Health Choice Arizona within thirty (30) calendar days from the receipt of the Health Plan's final claim dispute decision.

The Request for State Fair Hearing only needs to state that you do not agree with the decision. **Health Choice Arizona does not have a second level dispute process**; therefore please make sure that your request indicates "Request for State Fair Hearing" or your documentation may be returned.

Health Choice Arizona will forward a copy of the Request for State Fair Hearing and the Health Plan's file to the AHCCCS Office of Administrative Legal Service within five (5) working days. AHCCCS is responsible for scheduling the hearing. Hearings are held in person at the Office of Administrative Hearings (OAH). It is important that you know that a hearing means you must appear or your case will be dismissed. If you want to appear telephonically, you must submit that request to OAH. Both you and Health Choice Arizona will be notified by AHCCCS of the date and time of the hearing. Additional information about hearings can be found at the OAH website: www.azoah.com.

If at any time you wish to withdraw your request for hearing, it must be in writing and sent to OAH and to Health Choice Arizona. Motions can be sent to OAH either by fax or through their website. OAH's fax number is (602) 542-9827. Health Choice Arizona's fax number is (480) 760-
4619.

If you win the hearing, Health Choice Arizona will reprocess the claim in a manner consistent with the Decision within 15 business days of the date of the Director's Decision.

CHECKING THE STATUS OF YOUR DISPUTE

You will receive an Acknowledgement Letter within 5 working days. This will let you know that we have your case and that we are working on it. You can check the status and the outcome of your dispute by logging on or creating a Master Account at the Health Choice Arizona website:

https://www.healthchoicearizona.com/ProviderPortal/login/

If you request a State Fair Hearing, you will also be able to see the date we sent the request to AHCCCS, and the date that AHCCCS sets for the hearing.

APPEALS AND GRIEVANCES (FOR MEMBERS)

Occasionally a member may ask you how to file an appeal or a grievance (complaint) with Health Choice. You may also be asked to represent the member in the appeal. This information is also available in the Member Handbook and the Health Choice Arizona website.

MEMBER APPEALS

A member may file a Member Appeal with Health Choice Arizona in response to an action.

Action means:

- ☐ Denial or limited authorization of a requested service, including the type or level of service;
- ☐ Reduction, suspension, or termination of a previously authorized service;
- ☐ Denial, in whole or in part of payment for a service;
- ☐ Failure to provide services in a timely manner;

- ☐ Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
- ☐ Denial of a rural member's request to obtain services outside the Contractor's network when the contractor is the only Contractor in the rural area.

Most member appeals are because Health Choice Arizona has denied a request for a service (authorization for future service). Please refer to Chapter 6: Medical Authorizations and Notifications for details on Authorizations. If Health Choice Arizona does not make a decision on an authorization within the required time (as outlined in Chapter 6), then the member can consider the request "denied" and he/she can file an appeal.

When Health Choice Arizona denies a request for authorization, a *Notice of Adverse Benefit Determination (NOA)* is mailed to the member, and an explanation letter is mailed to the requesting provider. The member's NOA will advise the member on how to file an appeal.

If Health Choice Arizona is reducing, suspending or terminating an existing service, there are additional rights and rules that apply, other than just being able to file an appeal. Please refer to the Member Handbook on the Health Choice Arizona website at www.healthchoiceaz.com, or call our Member Services Department for details.

How a Member Files an Appeal

The member must file the Member Appeal, verbally by calling Member Services, or in writing, to Health Choice Arizona within sixty (60) days of the date on the Notice of Action (NOA). Only members can request an appeal of a prior authorization decision. However, a member is allowed to ask a physician, or anyone else such as a family member, to represent him/her in his/her appeal and/or hearing. However, the member must give written permission for the doctor to represent him/her. Health Choice Arizona has no policy that would prevent the provider from advocating on behalf of a member.

If your physician is representing the member in the appeal, you must include a copy of the member's written permission. Submit the appeal, and the representation authorization, directly to the Member Appeals Department at the address listed below:

Health Choice Arizona
Attention: Member Appeals
410 N. 44th St., Ste 900
Phoenix, AZ 85008

Once the Appeal process has been initiated, Health Choice Arizona will send the Member (and their representative, if applicable) an acknowledgment letter by regular mail. Health Choice Arizona will respond to all Appeals within thirty (30) days from the date that Health Choice Arizona received the Appeal. Health Choice Arizona will mail a final written decision to the Member (and their representative, if applicable). If an extension is necessary, Health Choice Arizona will notify the Member (and their representative, if applicable).

Most members file their appeals themselves. Even in this case, before we make our decision, we will ask the requesting provider for additional information to assist us in our determination of the Appeal.

To help Health Choice Arizona respond quickly to the member, please return this questionnaire to us as quickly as you can.

If waiting 30 days for a decision could seriously jeopardize members the life, health or the ability to attain, maintain or regain maximum function, the member, or the member's physician, can request an Expedited Appeal. In these instances the appeal will be decided within 72 hours of the receipt of the appeal. If Health Choice Arizona denies the Expedited Appeal and the member requests a Hearing, the Hearing will also be expedited.

An extension, up to 14 additional calendar days, can be requested by the member or Health Choice Arizona, if the extension is in the member's best interest.

MEMBER GRIEVANCES (COMPLAINTS)

A member may file a Grievance (formerly a member Complaint) with Health Choice Arizona regarding the dissatisfaction with any aspect of their care (other than the appeal of any Notice of Action letter (NOA). If a member wants to file a grievance, please direct him/her to Health Choice Arizona Member Services at (800) 322-8670, or inform him/her that he/she can submit his/her grievance in writing to:

Health Choice Arizona
Attention: Quality Management Department Member Grievance
410 N. 44th St., Ste 900
Phoenix, AZ 85008

If the grievance is against your office, Health Choice Arizona will contact you to get your input on the grievance.