Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

1.0 PURPOSE:

This policy communicates the Claim Disputes & Appeals Department ("CD&A" or "Department") process for handling claim disputes and requests for hearings applicable to the provider claim dispute process.

2.0 POLICY STATEMENT

Care1st Health Plan Arizona, Inc. (Care1st) investigates and renders claim dispute decisions and processes requests for hearing in accordance with the Arizona Health Care Cost Containment System (AHCCCS) statutory, regulatory and contractual requirements.

3.0 AUTHORITIES AND REFERENCES

- 42 CFR 438.10
- 42 CFR Part 438 Subpart F
- AAC R9-34 Parts 203 - 225
- AAC R9-34-201
- AAC R9-34-401
- ARS 36-2903.01(B)(4)
- Arizona Health Care Cost Containment System (AHCCCS) Contract, Attachment F2
- AHCCCS Contractor Operations Manual Policy 445
- Policy 1005 Document and Record Retention
- Policy 502 Prior Authorization and Referral

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

4.0 DEFINITIONS:

Adverse Benefit Determination:

a. denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity , appropriateness, setting, or effectiveness of a covered service
b. reduction, suspension, or termination of a previously authorized service
c. denial, in whole or in part, of payment for a service
d. failure to provide services in a timely manner, as defined by AHCCCS
e. failure to act within the timeframes required for standard and expedited resolution of and standard disposition of disputes
f. 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
g. denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities

Claim Dispute: A dispute involving payment of a claim, denial of a claim, or recoupment of a claim. Care1st resolves AHCCCS claim disputes submitted to the CD&A department within 30 days of receipt The AHCCCS claim dispute resolution timeframe may be extended an additional 14 days upon request and or the enrollee needs. Disputes not resolved in the required timeframe are considered denied and eligible for hearing request.

Complainant: The person or entity requesting the state fair hearing.

Day: A calendar day unless otherwise specified.

Director's Decision:	After the administrative law judge's recommendation, the decision of the administration as to the resolution of the claim dispute.
Member:	An eligible person who is enrolled in AHCCCS as defined in A. R.S. 36-2931, 36-2901, 36-2901.01 and A.R.S. 36-2981
Not a Grievance (NAG):	The name for an article addressed to and received by the Department, but where the action requested is not appropriately resolved by the same (e.g.: claim denied for lack of primary insurance Explanation of Benefits, the complainant then submits a letter addressed to the Appeals Dept but requests only reprocessing. This NAG is responded to by the Department and a copy of the corrected claim is forwarded to the Claims Department for adjudication).
Overturned:	The original decision of Care1st is reversed.
Provider:	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.
Remittance:	The notification to a provider advising of the Care1st adjudication disposition of one or more claims.
State Fair Hearing:	An administrative hearing under ARS Title 41, Chapter 6 Article 10.

5.0 OPERATING PROTOCOL

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

Care1st maintains a database for all claim disputes containing information to identify the complainant, provider, member, date of receipt, nature of the claim dispute, resolution of the claim dispute and the date the matter is resolved.

Care1st processes all claim disputes and requests for hearing in accordance with Federal and State laws and regulations. Unless otherwise provided by law, claim dispute records are maintained and secured electronically as outlined in our Document Retention Policy 1005 following the dispute decision, AHCCCS Director's Decision, judicial appeal, or close of the claim dispute, whichever is later.

As required by AHCCCS contract, all claim disputes are adjudicated in Arizona, including disputes from claims processed under a delegated agreement.

Timeframe for Filing a Dispute

All provider claim disputes challenging claim payments, denials or recoupments must be filed in writing with Care1st no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

Who May File

A provider or their representative may file a claim dispute. Members may not submit disputes on behalf of providers without the signed consent of the individual provider who stands to benefit from the action.

Contracted Providers are notified of the claim dispute process, its requirements and their obligations upon execution of a contract. Non-Contracted Providers receive the claim dispute policy information with their remittance advices no later than 45 days of receipt of a claim and also are directed to the Care1st website (http://www.care1stAZ.com) for the same information. A brief overview of the dispute process and where to submit is included with every remittance advice. All providers may receive a copy of the policy by contacting Care1st.

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

Filing Claim Disputes

Provider claim disputes must be filed in writing and by rule must identify, with specificity, the factual and legal basis for the dispute and relief requested. Care1st denies a claim dispute if the factual or legal basis is not detailed. All claim disputes challenging claim payments, denials or recoupments must be filed in writing with Care1st no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

Disputes must be addressed to:

Claim Disputes & Appeals
Care1st Health Plan Arizona, Inc.
432 N. 44th St., Suite 100
Phoenix AZ 85008

Receipt of Mail

The Appeals Intake Specialist receives mail every business day from any source that may have mail intended for and appropriately handled by the Claim Disputes and Appeals Department. All mail and documents are date stamped upon receipt by the Appeals Intake Specialist with the CD&A Department Received Mail Stamp regardless of any other received stamp on the article. The Appeals Intake Specialist stamps the mail with the date that the CD&A Department received the article.

For the purposes of entry, CD&A enters claim disputes into the database with the earliest receipt date of any agent of the plan.

E.G. The Claims Department receives a claims dispute on March 3rd, and erroneously categorizes it as a claim. On March 6th the Claims Department discovers it should be a dispute. The Claims Department forwards the dispute on March 6. CD&A stamps the matter with a March 6th date, however, enters the matter in the CD&A database as received March 3rd.

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

Sorting of Mail

The Appeals Intake Specialist sorts and triages mail received by the CD&A Department, identifying those matters that are appropriate to be addressed by CD&A. Mail determined to be true claim disputes appropriate for Department adjudication are routed to the logging process. Matters determined inappropriately addressed to CD&A are forwarded to the NAG process.

NAG Process

Matters addressed to the CD&A Department but not appropriately adjudicated by the same are NAGs. The Appeals Intake Specialist ensures NAGs are responded to with the standard NAG letter. All NAG matters are scanned electronically, then named with the date of receipt and stored in the NAG folder in the Appeals Drive on the network. The original is forwarded to the appropriate department for adjudication/resolution. A copy of the letter that prompted the action and the NAG letter is then sent to the party originating the action.

Logging Claim Disputes

Those matters deemed appropriate for resolution by the Department are entered into the CD&A database and assigned a tracking number. The matter is then assigned to a Disputes and Appeals Coordinator for research and resolution.

Acknowledgment Letters

Care1st acknowledges claim disputes in writing as expeditiously as possible but never greater than five business days from receipt. Expedited post service provider claim disputes are not permitted.

The Appeals Intake Specialist creates the acknowledgment letters utilizing the CD&A database.

Acknowledgments are directed to the individual or organization initiating the claim dispute, and to others as directed in the dispute request. The acknowledgement letter contains the following:

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

1. Member name
2. Member ID number
3. Requesting provider name
4. Dispute number
5. Date of receipt
6. Scope and nature of dispute
7. Expected resolution date
8. Right to submit additional information
9. Right to review the dispute and access copies of all documents relevant to the dispute

File Set Up

Files are maintained electronically and organized in such a way as to facilitate research of the matter. The electronic file is maintained in a neat and orderly fashion at all times. At a minimum, the claim dispute file contains:

1. The copy of the claim dispute
2. The acknowledgment letter
3. The decision letter when complete
4. Any information relevant to the resolution of the dispute

Request for Extension of Time

CD&A may extend the resolution timeframe for a claim dispute up to 14 days if the Disputes and Appeals Coordinator requires more time beyond the standard timeframe 30 days)to complete a claim dispute in order to collect additional information, or if the provider requests additional time to provide supporting documentation/testimony regarding the dispute. If Care1st extends the timeframe for resolution of a claim dispute, Care1st provides the provider with written notice of the reason for the delay.

Matters not resolved by the expiration of the claim dispute timeframe or extension, if exercised, are considered denied and eligible for state fair hearing request.

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

Who Resolves the Claim Dispute

Individual claim disputes are addressed by the Disputes and Appeals Coordinator. The Disputes and Appeals Coordinator is charged with identifying the issues presented on the dispute and ensuring the resolution of the claim dispute is timely and correct. Disputes and Appeals Coordinators solicit advice from and counsel with, individuals in other departments to identify how and why the claim paid or denied. Matters relating to medical necessity or involving clinical issues are forwarded to medical personnel for review and coordination. Individuals involved in making decisions at the coverage determination level, as well subordinates of the same, are barred from reviewing the matter at the claim dispute and request for hearing level. Clinical decisions are made by at least one person who is a provider/healthcare professional in the same or similar specialty that typically treats the medical condition or provides the treatment.

Disputes and Appeals Coordinators have a firm understanding of the Claim's Department and the Medical Management Department's policies and practices. Disputes and Appeals Coordinators are further charged with identifying gaps in policy or dispute trends and presenting such to departmental management for follow up. The Disputes and Appeals Coordinator documents the nature of the dispute resolution and the date of the resolution within the CD&A database. Disputes and Appeals Coordinators have the authority to require corrective action and the required experience to administer the claim disputes process.

Disputes and Appeals Coordinators render decisions based on the merits of the case before them only after exhaustive review of the matter and ensuring that relevant facts are obtained from all parties. Claim disputes are thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions. Where reasonable and appropriate, the Disputes and Appeals Coordinator attempts to solidify the argument of the provider by contacting the disputing party or agent and having them fill in the details of their dispute that may be absent from the letter of dispute. AHCCCS claims disputes are resolved within 30 days of receipt unless an extended timeframe is requested by either Care1st or the provider.

Notice of Claim Dispute Resolution

After research is completed and Care1st has come to a final decision regarding the resolution of the claim dispute, a written notice of dispute resolution letter is mailed no later than 30 days after the provider files a claim dispute, unless an extension is agreed upon with the provider.

The notice of dispute resolution letter must include the following:

1. The nature of the claim dispute
2. The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member name, pertinent dates of service, date and specific reasons for the dispute denial or payment of the claim and whether or not the provider is contracted with Care1st
3. The reasons supporting Care1st's decision, including an explanation of:
    - how Care1st applies the relevant and specific facts in the case to the relevant laws to support the our decision; and
    - the applicable statues, rules, contractual provisions, policies, and procedures. Reference to general legal authorities alone is not acceptable.
4. The provider's right to request a State Fair Hearing by filing a written request to Care1st no later than 30 days after the date the provider receives the resolution letter.
5. If the claim dispute is overturned, in full or in part, Care1st shall reprocess and pay the claim(s) in a manner consistent with the decision and within 15 business days of the date of the resolution letter.

Matters not resolved by the expiration of the dispute timeframe or extension, if exercised, are considered denied and eligible for state fair hearing request.

Care1st reprocesses and pays all overturned and partially overturned claim disputes, along with any applicable interest, within 15 business days of the date of the decision. Whenever possible, overturned and partially overturned claim disputes are reprocessed and paid within a timeframe that allows the Disputes and Appeals Coordinator to include the new claim number and payment amount in the notice of decision.

Care1st's decision resolves all relevant and/or reasonable issues presented. Upholding a claim dispute does not constitute a guarantee of payment or waiver of claim filing requirements. A decision relates to the issue investigated only. Claim disputes forwarded for further claim processing are subject to all other applicable edits.

Providers or their representatives may contact CD&A for questions about the provider claim dispute process.

After the Resolution

Once a decision is made and a Notice of Decision letter is sent to the party filing the dispute, the Disputes and Appeals Coordinator includes a copy of the letter in the dispute file. The Coordinator saves an electronic version of the dispute in the appropriate drive and folder.

AHCCCS Request for State Fair Hearing

Providers, who disagree with the Notice of Claim Dispute Resolution (the Notice of Decision), must submit a written request for hearing to:

Request for State Fair Hearing
Claim Disputes & Appeals
Care1st Health Plan Arizona, Inc.
432 N. 44th St., Suite 100
Phoenix AZ 85008

Requests for hearing are entered into the Hearing tab and tracked in the CD&A database. A request for State Fair Hearing is timely when it is received within 30 days of the provider's or member's receipt of the decision letter. Upon receipt of a request for hearing the Appeals Regulatory Coordinator has five business days to submit a Request for Hearing Cover Sheet and supporting documentation to the AHCCCS Office of Administrative Legal Services (OALS).

The hearing file content submitted to OALS must include:

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

1. The Request for Hearing Cover Sheet
2. The complainants written request for state fair hearing
3. The Notice of Dispute Decision letter
4. The claim dispute with pertinent documentation

Once a hearing file is submitted to AHCCCS, additional information or supporting documentation is filed as exhibits with the Office of Administrative Hearings. The AHCCCS/OLS is responsible for scheduling and notifying parties of the date, location and time of hearing.

Review of a hearing request requires a different Disputes and Appeals Coordinator or Appeals Regulatory Coordinator who did not participate in the claim dispute resolution, to review the matter to determine why a request for hearing was filed and, when appropriate, resolve the matter outside of the hearing process. The Appeals Regulatory Coordinator reviews the dispute denial and request for hearing with CD&A management.

Overturned Hearing Decisions

If the Care1st claim dispute decision or the AHCCCS Director's Decision reverses a decision to deny, limit or delay services not furnished during the dispute or pending the hearing process, Care1st shall authorize or provide the service as expeditiously as the member's health condition requires, but no later than 15 business days, regardless of the intention to contest the Director's Decision. The Appeals Regulatory Coordinator monitors the claim payment, with any applicable interest, or authorization status to ensure that the appropriate action(s) are rendered within the required timeframe.

Tracking and Trending

The Disputes and Appeals Coordinator ensures that all applicable and appropriate descriptor fields of the CD&A database are completed. The database contains a number of data elements, such as the complainant, provider name, member name and AHCCCS ID, the date of receipt, the nature of the claim dispute, the resolution of the claim dispute, the date of resolution, hearing request file date, when requested, and other data elements to sufficiently track and monitor claim

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

disputes. Disputes and Appeals Coordinators are encouraged to share any trends perceived or expected with department management. Management regularly reviews the data to determine whether any trends or quality improvement opportunities can be identified and presented to the interested functional area. Claim disputes are archived in a file following the dispute resolution, the Director's Decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law. Archived files are maintained and managed in a manner that preserves confidentiality and security of records. Care1st observes the retention timeframes identified in its contracts and as required by law. Policy 1005 Document and Record Retention provides additional details.

6.0 REVISION HISTORY

Date	Reviewed/Revised By:	Reason for change
09/2019	Kim Lenzi	Annual Review/Revision
04/2018	Kim Lenzi	Annual Reviewed
09/2017	Kim Lenzi	Mega Rule Changes
06/2017	Kim Lenzi	Policy Revision
10/2016	Kim Lenzi	Policy Revision
06/2016	Kim Lenzi	Policy Revision
06/2015	Daniel de la Vara	Policy Revision
05/2014	Daniel de la Vara	Annual Review
12/2013	Daniel de la Vara	Policy Revision
07/2013	Daniel de la Vara	Annual Review
12/2012	Daniel de la Vara	Policy Revision
12/2011	Daniel de la Vara	
12/2010	Daniel de la Vara	
08/2009	Daniel de la Vara	
09/2008	Daniel de la Vara	
11/2007	Daniel de la Vara	
11/2006	Kimulet Winzer	
07/2005	Kimulet Winzer	
11/2004	Kimulet Winzer	

Policy Name: Provider Claim Disputes & Requests for Hearing	
Policy Number: 603	Department: Claim Disputes & Appeals
Original Effective Date: 10/01/2003	Page(s): 14
Applies to: ▪ AHCCCS	

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Applies to: ▪ AHCCCS	

7.0 CORPORATE APPROVAL:

Scott Cummings State President	Deena Sigel VP Field Finance