Ambetter from Arizona Complete Health

APPEALS

Arizona law requires Arizona Complete Health (AzCH) to ensure a process for members to appeal denied claims or denied services.

- A “denied claim” is when the member has already received care, the treating provider submitted a claim, and AzCH has denied the claim.
- A “denied service” is when AzCH denies a prior authorization request for a service covered in the member’s policy that the member or treating provider believe is medically necessary.

When AzCH denies a claim or authorization for a covered service, members receive information regarding the right to appeal the denial. The appeals process only occurs if the member or treating provider have specifically requested that AzCH reconsider its initial decision. The AzCH appeals process consists of the following levels of review:

For urgently needed services not yet provided:
1. Expedited Medical Review
2. Expedited Appeal
3. Expedited External Independent Review

For standard services or denied claims
1. Informal Reconsideration (ONLY available for pre service denials)
2. Formal Appeal
3. External, Independent Review

Appealable decisions by the AzCH include:
- AzCH does not approve a service that the member or treating provider have requested.
- AzCH does not pay for a service that the member has already received.
- AzCH does not authorize a service or pay for a claim because it is determined not medically necessary.
- Notification of the AzCH authorization request determination not received within 10 business days of receiving a service request.
- AzCH does not authorize a referral to a specialist.

Treating providers are not required to get any special permission to represent members in pre service Appeals proceedings.

To ensure that AzCH processes the disputes correctly, to request a post service claims payment appeal on behalf of a Plan member; please complete the dispute resolution form available in the resource section

https://ambetter.azcompletehealth.com/content/dam/centene/ambetteraz/pdfs/508_Ambetter%20A%26G%20Representative%20Form%20Rev%20042019.pdf

CLAIMS PAYMENT RESUBMISSIONS AND RECONSIDERATIONS

Providers have two options for resolving claims payment disputes:

1. Claims Resubmission for resubmitting claims with incorrect, or inaccurate information
2. Claims Reconsiders to request exception or review of payment accuracy

Indicate the type of review requested, "Claim Resubmission" or "Claim Reconsideration" and forward to:

Claim Resubmission
Claims Department
Ambetter from Arizona Complete Health
P.O. Box 9040
Farmington, MO 63640-9040

Claim Reconsiderations
Claims Department
Ambetter from Arizona Complete Health
P.O. Box 9040
Farmington, MO 63640-9040

PROVIDER GRIEVANCE

Provider grievances are the expressed dissatisfaction for issues that do not qualify as appeals. Examples include:

- Provider materials (e.g. Provider Manual) inaccurate and/or insufficient
- Claims payment resubmission or reconsideration outcome
- Network provider's difficulty reaching assigned Engagement Specialist to resolve issues
- Plan responsiveness to requests for technical assistance.

All level grievances for non-claims payment, and claims payment related provider grievances must sent in writing to:

Mail: Ambetter from Arizona Complete Health
Attention: Provider Grievance
Ambetter from Arizona Complete Health
P.O. Box 9040
Farmington, MO 63640-9040

Email: AzCHMarketplace2@azcompletehealth.com or

Fax: (866) 461-7012

AzCH acknowledges all provider grievances filed within five business days from the date of receipt of the grievance request.

AzCH does not request records to support a grievance. AzCH determines the provider grievance response based on information submitted by the provider with the grievance request and records previously received.

The Ambetter A&G Department is responsible for documenting the entirety of the provider grievance process including: initial request, scanning copy of the initial request, issuing acknowledgement of the grievance filling, research and plan response in the A&G software system.

<u>Non Claims Payment Provider Grievances</u>

Level 1: Non-Claims Payment Provider Grievances

Providers may file grievances not related to claims payments for up to 180 days after the incident consideration to review cases older than 180 days on a case-by-case basis. Providers must file grievance in writing.

The Ambetter A&G Department reviews all provider non-claims payment grievances, and mails a written response, including any outcomes of the research within sixty calendar days of the grievance filing. With the exception of out of state providers, AzCH mails its decision letter to the most recent address on file.

If the Ambetter A&G Department is unable to make a determination within the sixty-day timeframe due to matters beyond its control, it may extend the decision timeframe once; for up to an additional fourteen calendar days. Providers receive written notification of any extensions.

Level 2: Non-Claims Payment Related Provider Grievances

Providers have sixty calendar days from the date of the Level 1 response letter to file a Level 2 non-claims payment related grievance.

Providers may extend the sixty-day time for up to an additional sixty calendar days if AzCH receives written notification of the need for an extension within the initial sixty-day period.

Requests for Level 2 grievances should include an explanation for dissatisfaction with the Level 1 decision and any applicable new information for consideration.

AzCH mails the written response for Level 2 grievances, including any outcomes of the research within sixty calendar days of the grievance filing. With the exception of out of state providers, AzCH mails its decision letter to the most recent address on file.

AzCH may extend this sixty-day review for an additional thirty calendar days. Providers receive written notification of any extensions within the sixty-day review period.
Claim Payment Related Provider Grievances

<u>Claims Payment Provider Grievances</u>

Provider options to resolve payment disputes include:

1. Claim Resubmission (missing or additional information)

2. Claim Reconsideration (additional information or justification)
3. Claims Payment Related Provider Grievance

When a provider disagrees with the payment, or denial of a claim, and the issue has not been resolved via the claims resubmission or reconsideration processes, the provider may initiate the provider grievance process (the "grievance process"). The AzCH Provider Grievance process includes two levels of review. Provider grievance issues may include, but are not limited to:

- Whether a claim was clean
- Failure to timely pay a claim
- Amount paid (bundling software)
- Amount paid (other than bundling software)
- Amount or timeliness of interest payment
- Adjustment request
- Denials that require a provider write-off (for example: investigational/ experimental)
- Network adequacy (other than the provider's contract status)
- Systemic or operational problems
- Coordination of Benefits (COB) issues
- Coinsurance/deductible and sanction deductible
- Fee schedule disputes
- Outpatient global pricing
- DRG payment
- Fragmentation of incidental procedures
- Modifiers
- Multiple medical/surgical procedure processing
- Mutually exclusive procedures
- Procedure unbundling
- Timely filing

Claim Corrections after Filing a Grievance

A claim reviewed under the AzCH Provider Grievance Process may not be corrected post submission; therefore, providers receive instruction to ensure that all information included in the claim is accurate prior to filing.

Level 1 Claims Payment Related Provider Grievance

For Level 1 grievances, providers have up to one year after the date of an AzCH explanation of payment (EOP), or other claim processing related communication (e.g. claim rejection notice) to file a WRITTEN claim related provider grievance.

AzCH has discretion to extend this one-year time for good cause or if longer period is required by state or federal law. "Good cause," as used in this section, means circumstances beyond the reasonable control of the provider and that prevented the provider from submitting a timely grievance request as determined by AzCH.

Provider Grievance filings should include:

- Reference to, or copy of, the action under dispute
- Written explanation of why the action is wrong, and the relief requested
- Applicable documentation (e.g. medical records, operative reports, or office notes, etc.)

A&G Staff not involved in the initial determination, reviews the grievance including any new information submitted.

Level 2: Claims Payment Related Provider Grievances

Providers have sixty calendar days from the date of the Level 1 response letter to file a Level 2 non-claims payment related grievance.

Providers may extend the sixty-day time for up to an additional sixty calendar days if AzCH receives written notification of the need for an extension within the initial sixty-day period.

Requests for Level 2 grievances should include an explanation for dissatisfaction with the Level 1 decision and any applicable new information for consideration.

AzCH mails the written response for Level 2 grievances, including any outcomes of the research within sixty calendar days of the grievance filing. With the exception of out of state providers, AzCH mails its decision letter to the most recent address on file.

AzCH may extend this sixty-day review for an additional 30 calendar days. Providers receive written notification of any extensions within the sixty-day review period.

Timely Filing

Initial Claims		Resubmission and Reconsiderations		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
120 days	365 days	365 days	365 days	120 days - From the primary payers EOP date to the date received.	365 days - From the primary payers EOP date to the date received.

- **Initial Claims** - Days calculated from the Date of Service to the date received by Ambetter or from the EOP date. For observation and inpatient stays, the date calculated from the date of discharge.
- **Claim Resubmission** - Days calculated from the Date of Service to the date received by Ambetter or from the EOP date. For observation and inpatient stays, the date calculated from the date of discharge.
- **Claims Reconsiderations** - Days calculated from the date of the Explanation of Payment issued by Ambetter to the date received.

- **Coordination of Benefits** - Days calculated from the date of Explanation of Payment from the primary payers to the date received.