TITLE Grievance, Appeals and Claim Disputes	POLICY NUMBER AD-CO-01
RESPONSIBLE FUNCTION AREA Compliance	APPROVED 10/31/2022
Initiated: 11/23/88 **Reviewed:** 05/02/02; 12/01/04, 10/13/05, 02/09/06; 03/30/07; 12/10/08; 11/04/09; 10/04/10; 10/17/11; 11/30/12; 08/27/13; 04/30/14; 10/21/14; 03/12/15; 06/15/16; 07/20/17; 8/31/18, 10/31/19; 10/31/22	

STATEMENT/PURPOSE

This policy is intended to ensure a thorough, appropriate and timely resolution to member grievances and appeals.

AUTHORITY

42 C.F.R. 438.400 (3). Grievance System. Statutory basis and definitions.

42 C.F.R. 438.408. Resolution and notification: Grievances and appeals.

A.R.S § 36-2903.01. Additional powers and duties; report; definition.

A.R.S. § 36-2912. Children's Rehabilitative Services program; definition.

A.A.C. § R9-34-201-225. Appeal, Grievance, and State Fair Hearing for an Enrolled Person.

A.A.C. § R9-22-1301-1309. Children's Rehabilitative Services (CRS).

A.A.C. § R9-34-401. Claim Dispute.

A.A.C. § R21-1-301-314. Appeals and Hearing Procedures.

A.A.C. § R21-1-207. Payment and Review of Claims.

The Intergovernmental Agreement (IGA) between the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Child Safety (DCS) for Mercy Care DCS CHP (DCS CHP) outlines the contractual requirements for compliance with continuity and quality of care coordination for all members.

The contract between the Department of Child Safety (DCS) for the Comprehensive Health Plan (CHP) and its contracted Managed Care Organization (MCO) outlines the contractual requirements for compliance with quality and appropriateness of care/services.

DEFINITIONS

Action: An Action is

- The denial or limited authorization of a requested service, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service
- The denial in whole or in part of payment for a service
- The failure to provide a service in a timely manner
- The failure to act within the timeframes specified.

Adverse Benefit Determination: The denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service.

Appeal: A request for a review of an adverse benefit determination.

Authorized Representative: A person who is authorized to apply for medical assistance or act on behalf of another person.

Claim Dispute: A dispute, filed by a health care provider involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Department of Child Safety (DCS): The regulatory oversight body of the Managed Care Organization (MCO)

Expedited Appeal Decision: DCS CHP must resolve all expedited appeals not later than three (3**)** business days from the date DCS CHP received the appeal.

Grievance: A member's expression of dissatisfaction with any matter, other than an adverse benefit determination.

Mercy Care DCS CHP: The Managed Care Organization (MCO)

Notice of Adverse Benefit Determination (NOA): The written notice to the affected member regarding an adverse benefit determination by DCS CHP.

Notice of Appeal Resolution: A written notification to notify members; requesting provider (with member's consent) or authorized representative acting on behalf of the member of the decision made to overturn and approve services requested; or, the decision to uphold the original decision not to approve or reduce a requested service.

Oversight: DCS regulatory review of the MCO's grievances, appeals, and claims disputes process(es) and outcomes.

Restriction: A member who meets certain drug overutilization criteria as outlined in HS MM 05 may be restricted to an exclusive pharmacy and/or an exclusive provider.

State Fair Hearing: An administrative hearing as defined under A.R.S. Title 41, Chapter 6, Article 10 and A.A.C. § R21-1-301.

POLICY

A member, caretaker or an authorized representative, including a health care provider acting on behalf of the member, with written consent, can file a grievance with DCS CHP to express dissatisfaction with any matter other than an adverse benefit determination. There are no time limits for filing a grievance. A grievance may be filed orally or in writing.

A member, caretaker or an authorized representative, including a health care provider acting on behalf of the member, with written consent, can file an appeal of an adverse benefit determination made by DCS CHP when a service authorization is denied or reduced.

Punitive action is not taken against a member who files a grievance or appeal, or a health care provider who files or supports a member's grievance or appeal, or who requests expedited resolution of a member's grievance or appeal.

Reasonable assistance is provided to members in completing forms and taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications devices, for the deaf, and text telephone) and interpreter capability.

DCS CHP instructs health care providers to file written claim disputes when challenging payments or denials of claims. Claim disputes include the factual and legal basis for the dispute, the relief requested and documents supporting the facts of the dispute. Claim disputes lacking specificity may be denied.

Health care provider claim disputes are filed in writing as follows:

- Within 12 months from the date of service;
- Within 12 months from the date that eligibility is posted; or
- Within 60 days from the date of the payment, denial or recoupment of a timely claim submission, whichever is later.

DCS CHP reviews all health care provider claim disputes and issues a Notice of Decision letter. If the decision is unfavorable, the health care provider has 30 days from receipt of the decision letter to request a State Fair Hearing.

PROCEDURE

Grievances

A member or an authorized representative, including a Provider acting on behalf of the Member (with written consent), can file a Grievance. There are no time limits for filing a Grievance. A Grievance can be filed orally by contacting the Member Services department via DCS CHP's toll-free number or in writing.

DCS CHP is not required to acknowledge receipt of the Grievance in writing; however, when Members request written acknowledgement, DCS CHP sends acknowledgement within five (5) business days of receipt of the request. Grievances must be filed directly to DCS CHP. Members are not entitled to a State Fair Hearing on a Grievance.

DCS CHP resolves most Grievances immediately upon receipt or within ten (10) business days of receipt, absent extraordinary circumstances. All Grievances are resolved within ninety (90) calendar days of receipt. Oral and written Grievances are logged into DCS CHP'S Health Information System (HIS) Call Tracking Module. If the Grievance is resolved to the complainant's satisfaction at the time of the call, the resolution is recorded and the Grievance is closed. Grievances that are not resolved immediately are researched and reviewed by appropriate staff. When the Grievance is resolved the complainant is contacted to ensure satisfaction with the decision, and the Grievance is closed in the (HIS) Call Tracking Module. If a written explanation of the resolution is requested by the complainant, DCS CHP mails a response within ten (10) calendar days of receipt of the Grievance.

Grievances involving clinical issues are researched and reviewed by the appropriate health care professionals with the appropriate clinical expertise in treating Members' conditions or diseases. Individuals who make decisions regarding Grievances are not involved in any previous level of review or decision-making.

Member Appeals

In accordance with the Federal Regulations and AHCCCS rules, Members, or Providers acting on members' behalf, may challenge the denial of coverage of, or payment for, medical assistance.

Members are given reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

A member and/or their representative is given the opportunity before and during the appeal process to review the case file, including medical records, and any other documents and records considered during the appeal process.

The member and/or his representative or legal representative is included as a party to the appeal.

Standard Appeal

An Appeal is the request for review of an action as defined above. Standard Appeals may be filed either orally or in writing and must be filed within sixty calendar (60) days after the date of the NOA.

Oral and written standard Appeals are acknowledged in writing within five (5) business days of receipt, and, a "Notice of Appeal Resolution" (as defined above) is provided in writing within thirty (30) calendar days of receipt unless a fourteen (14) day extension is in effect. Decisions regarding Appeals are determined by qualified individuals who were not involved in any previous level of review or decision-making. Decisions regarding Appeals of denials based on lack of medical necessity, Grievances regarding a denial of expedited resolution of an Appeal involving clinical issues are always made by health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the member's condition or disease.

DCS CHP provides a written Notice of Appeal Resolution to the member within thirty (30) calendar days of receipt, which contains the following:

A. The date the resolution was completed and the results of the resolution process, including the legal citations or authorities supporting the decision;
B. The member's right to request a State Fair Hearing for Appeals not resolved wholly in their favor, including the standards required to request a fair hearing;
C. The right to receive benefits pending the hearing and how to request continuation of benefits; and
D. Information explaining that the member may be held liable for the cost of benefits if the AHCCCS Director's decision upholds DCS CHP's decision.

If DCS CHP needs additional information, and an extension is in the best interest of the member, DCS CHP extends the timeframe up to an additional fourteen (14) calendar days. If the timeframe is extended, DCS CHP:

A. Gives the member written notice of the reason for the decision to extend the timeframe, and
B. Issues and carries out the resolution as expeditiously as the member's health condition requires and no later than the date the extension expires.

Members may request an extension of the thirty (30) calendar day timeframe. When requested, the extension allows up to fourteen (14) additional calendar days.

If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's Appeal shall be considered to be denied by DCS CHP, and the member can request a State Fair Hearing.

Expedited Appeal

The member's health care Provider must provide documentation to support the request for an expedited Appeal. Expedited Appeal requests are acknowledged in writing within one (1) business day. If the documentation warrants, a decision is provided within seventy-two (72) hours. If not warranted, the member is contacted within seventy-two (72) hours, orally and in writing, stating that the request was not warranted and a decision is then made within thirty (30) calendar days.

If DCS CHP denies a request for expedited resolution, the appeal is transferred to the thirty (30) calendar day timeframe for a standard appeal.

If DCS CHP needs additional information, and an extension is in the best interest of the member, DCS CHP extends the timeframe up to an additional fourteen (14) calendar days. If the timeframe is extended, DCS CHP:

A. Gives the member written notice of the reason for the decision to extend the timeframe; and
B. Issues and carries out the resolution as expeditiously as the member's health condition requires but no later than the date the extension expires.

If an Appeal is not resolved wholly in favor of the member, the Notice of Appeal Resolution will contain the following:

A. The factual and legal basis for the decision;
B. The right to request to receive services while the State Fair Hearing is pending and how to make the request; and
C. The right to request a State Fair Hearing, and the process to do so.

Members may request an extension of the thirty (30) calendar days timeframe. When requested, the extension allows up to fourteen (14) additional calendar days.

If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's Appeal is considered to be denied by DCS CHP, and the member can file a Request for Hearing.

Member State Fair Hearing for Title XIX Members

Members may request a State Fair hearing on an Appeal. All requests must be in writing and received by DCS CHP no later than thirty (30) calendar days after the date the member received the Notice of Appeal Resolution. Hearings can be requested for non-Title XIX and Title XXI eligible individuals but, Title XIX and Title XXI eligible individuals must follow A.R.S. § 36-2903.01 and A.A.C. § R9-34 and may request an Administrative Hearing through the Arizona Health Care Cost Containment System.

Members have the right to: (1) present evidence and allegations of fact or law, in person and/or in writing; (2) reasonable opportunity before and during the Appeal process to examine their case file not protected from disclosure by law; and (3) reasonable assistance from DCS CHP for the purpose of completing forms or navigating the Grievance system.

Members may request continuation of services while an Appeal or State Fair Hearing is pending. The request to continue services must be in writing.

Upon receipt of a State Fair Hearing request DCS CHP forwards the request to the AHCCCS Office of Administrative Legal Services (OALS) within (5) business days. Attached to the request is the entire case file, any other pertinent information and a cover letter.

The cover letter includes the following information:

A. Member's name;
B. Member's DCS CHP and AHCCCS ID number;
C. Member's address if available;
D. Member's phone number if available;
E. Date of receipt of the Appeal; and
F. Summary of DCS CHP's action taken to resolve the Appeal and a summary of the resolution.

The documentation submitted includes the following:
A. The member's written request for hearing;
B. Copies of the entire Appeal file;
C. DCS CHP's Notice of Appeal Resolution; and
D. Other information relevant to the resolution of the Appeal.

If warranted and timely, the OALS mails a Notice of Fair Hearing to DCS CHP and the member. After the Hearing has taken place, AHCCCS mails the Director's Decision no later than thirty (30) calendar days after the date of the Administrative Law Judge's recommended decision, and within ninety (90) calendar days after the member filed the Appeal with DCS CHP. These timeframes do not include the number of days the member took to file for a State Fair Hearing or the days for continuances granted at the member's request.

Expedited State Fair Hearing for Title XIX Members

Members may request an Expedited State Fair Hearing on DCS CHP's resolution of an expedited Appeal. The request must be in writing, submitted and received by DCS CHP no later than thirty (30) calendar days after the member received the Notice of Appeal Resolution.

Upon receipt of an Expedited State Fair Hearing request, DCS CHP forwards, within the AHCCCS contracted timeframe, the case file and information along with a coversheet to the AHCCCS OALS.

Within three (3) business days of receiving the case file and information from DCS CHP, AHCCCS mails the AHCCCS Director's Decision to the member, which resulted from the State Fair Hearing and the Administrative Law Judge's Recommended Decision.

State Fair Hearing for Non-Title XIX Members

A member or an authorized representative, who disputes an adverse action may appeal and request an administrative hearing from the Department to challenge the adverse action.

DCS CHP services or benefits for non-Title XIX and Title XXI eligible individuals is an acceptable adverse action. Title XIX and Title XXI eligible individuals must follow (A.R.S.) § 36-2903.01 and (A.A.C.) R9-34, and may request an Administrative Hearing through the Arizona Health Care Cost Containment System.

A member or an authorized representative who wishes to appeal an adverse action must file a written request within 20 days after receipt of the adverse action notice.

DCS/CHP provides a form for requesting an administrative hearing and, upon request, shall assist an appellant in completing the form.

An appellant must include the following information in the request for an administrative hearing:

A. Name, address, and telephone number, and if applicable, e-mail address of the person subject to the adverse action;
B. Identification of the Administration initiating the adverse action;
C. A description of the adverse action that is the subject of the appeal;
D. The date of the notice or letter of adverse action; and
E. A statement explaining why the adverse action is unauthorized, unlawful, or an abuse of discretion.

DCS CHP does not deny an appeal solely because the request does not include all the information listed above, so long as the request contains sufficient information for the Department to determine the identity of the appellant.

DCS CHP forwards the request for a hearing to the Office of Administrative Hearings (OAH) within two (2) business days of receipt of the request.

If the Department Director reviews the ALJ's recommended decision, the Director may agree or disagree with the recommended decision as permitted in A.R.S. § 41-1092.08(F).

The Department Director's final administrative decision becomes effective on the day OAH certifies the Department Director's final administrative decision.

If the Department Director chooses not to review the recommended decision, then the ALJ's recommended decision becomes the final administrative decision within the timeframe under A.R.S. § 41-1092.08.

If the final administrative decision affirms the adverse action, the adverse action remains in effect until the appellant appeals and obtains a higher judicial decision reversing or vacating the final administrative decision.

Continuation of Services

Requests for continuation must be filed within ten (10) calendar days after the date DCS CHP mailed the NOA or the effective date of the action as indicated in the NOA.

Services continue if:

A. The Appeal is filed before
    - the later of ten (10) calendar days from the mailing of the NOA or

- The intended effective date of DCS CHP's proposed Adverse Benefit Determination or restriction;

B. The Appeal involves the termination, suspension or reduction of previously authorized course of treatment;
C. The Appeal involves a denial, and the physician asserts the requested service/ treatment is necessary for continuation of a previously- authorized service;
D. Services were ordered by an authorized Provider;
E. The original period covered by original authorization has not expired; and
F. The member requests that services continue.

Services continue until one of the following occurs:

A. The member withdraws the Appeal;
B. Ten (10) calendar days pass after the Notice of Appeal Resolution has been mailed and the member has not requested a State Fair Hearing; or
C. AHCCCS mails an adverse Director's Decision (determined after State Fair Hearing) to the member (custodial agency representative).

If the AHCCCS Director's or Department Director's Decision upholds DCS CHP's decision, DCS CHP may recover the cost of the services furnished to the member while the Appeal was pending.

If DCS CHP or the AHCCCS Director's Decision reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, DCS CHP authorizes the disputed services promptly and as expeditiously as the member's health condition requires.

If DCS CHP or the AHCCCS Director's Decision reverses a decision to deny authorization of services, and the member received the disputed services while the Appeal was pending, DCS CHP pays the Provider for those services.

Claim Disputes

Claim disputes are disputes involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Providers in the Credentialed Provider Network can locate the Claims Dispute Process in Chapter 10 (*Claim Disputes and Member Appeals*) within the DCS CHP Provider Manual. Non-Credentialed Providers may receive a copy of the Claims Dispute process with a remittance advice and/or mail if requested.

Claims Dispute records are maintained by DCS CHP in a secure designated area and retained for five (5) years following: DCS CHP's decision, the AHCCCS' decision, Judicial Appeal or close of the Claims Dispute, whichever is later, unless otherwise provided by law.

Claims Disputes must specify in detail the factual and legal basis for the dispute and the relief requested. All disputes, with the exception of those challenging claim denials, must be filed with DCS CHP no later than sixty (60) calendar days from the date of the adverse action.

Claims Disputes challenging a claim denial must be filed in writing with DCS CHP within twelve (12) months after the date of service, within twelve (12) months after the date that eligibility is posted or within sixty (60) calendar days after the date of the denial of a timely claim submission, whichever is later.

All Claims Disputes are date-stamped upon receipt. Within five (5) business days of receiving a dispute, DCS CHP informs the Provider by letter that the dispute has been received and the expected resolution date.

DCS CHP logs all Claims Disputes in the Grievance Tracking System with the following information: Member name, Date of receipt, Decision due date, Date resolved, Final resolution, Number of days to resolve, Nature of the dispute and the Complainants name information to identify the Complainant, Date of Receipt, Nature of the claim dispute and the date the claim dispute is resolved.

All resolutions (Notices of Decision) are mailed to the Provider no later than thirty (30) calendar days after the Provider filed the Claim Dispute, unless DCS CHP and the Provider have agreed to an extension.

All Claims Disputes are thoroughly investigated by the Dispute and Appeal Manager and the appropriate qualified staff, using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.

Upon resolution, the Dispute and Appeal Manager provides a written Notice of Decision to the Provider via certified mail, which includes, but is not limited to, the following:

A. The nature of the claim dispute.
B. 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, dates and specific reasons for DCS CHP's denial / payment of the claim, and whether or not the Provider is a contracted Provider.
C. The reasons supporting DCS CHP's Decision, including an explanation of
    1) How the DCS CHP applies the relevant and specific facts in the case to the relevant laws to support DCS CHP's decision and;
    2) The applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable.
D. The Provider's right to request a hearing by filing a written request to DCS CHP no later than 30 calendar days after the date the Provider receives the Decision.
E. If the claim dispute is overturned, in full or in part, the requirement that the DCS CHP shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the Decision.

Upon reversal of a denial, the DCS CHP Dispute and Appeal Manager coordinates the reversal of the denied payment with the Claims Manager to ensure payment is made within fifteen (15) business days of the date of the decision.

Provider State Fair Hearing Request

Providers may request a State Fair Hearing on the DCS CHP Notice of Decision by filing the request in writing to DCS CHP no later than thirty (30) calendar days and no later than fifteen (15) calendar days for non-Title XIX-funded members, after the date the Provider received the Notice of Decision. Hearings can be requested for non-Title XIX and Title XXI eligible individuals but, Title XIX and Title XXI eligible individuals must follow (A.R.S.) § 36-2903.01 and (A.A.C.) R9-34, and may request an Administrative Hearing through the Arizona Health Care Cost Containment System.

If DCS CHP fails to render a written Notice of Decision within the thirty (30) calendar days the Provider may file a written request for a State Fair Hearing within thirty (30) calendar days after the date that the Notice of Decision should have been mailed.

The date of the decision is the date of personal delivery or mailing.

The final decision informs the complainant of the right to a Fair Hearing to:

A. The AHCCCS OALS, if the child is Title XIX; or
B. XIX.

State Fair Hearing

If a State Fair Hearing is requested on DCS CHP's final decision, DCS CHP forwards the following information in a cover letter to the appropriate Office of Administrative Legal Services (AHCCCS or DES) no later than five (5) business days from the date DCS CHP received the request:

A. Provider's name;
B. Provider's AHCCCS ID number;
C. Provider's address;
D. Provider's phone number (if applicable);
E. The date of receipt of the claim dispute; and
F. A summary of DCS CHP's actions undertaken to resolve the claim dispute and the basis of the determination.

The following documentation is also included with the cover letter sent to the appropriate OALS:

A. Written request for hearing filed by the Provider;
B. Copies of the entire file, which includes pertinent records, and DCS CHP's decision;
C. DCS CHP Notice of Decision; and
D. Other information relevant to the Notice of Decision of the claim dispute.

AHCCCS mails a Notice of Hearing for Title XIX and Title XXI members to the parties if DCS CHP receives a timely Request for Hearing from the Provider.

After the Hearing has taken place, AHCCCS mails the AHCCCS Director's Decision no later than thirty (30) calendar days after the date of the Administrative Law Judge's recommended decision and within ninety (90) calendar days after the member filed the dispute with DCS CHP.

Record Keeping

DCS CHP maintains logs for all grievances, appeals and claim disputes, containing sufficient information to identify:

A. Member name;
B. Date of receipt;
C. Decision due date;
D. Date resolved;
E. Final resolution;
F. Number of days to resolve;
G. Nature of the dispute;
H. Complainants name.

The privacy of these records are maintained at all times, including the transmittal of medical records. All documents are filed in a secure, designated area and retained for five (5) years following DCS CHP's decision, AHCCCS or DES decision, judicial appeal or close of the dispute, whichever is later.

Circumvented Process

Members and Providers who wish to circumvent the established DCS CHP processes, may contact the DCS CHP Program Administrator to discuss mechanisms for resolving the issue external of the DCS CHP process. These include: conversations with AHCCCS, the Administrator, or other members of DCS CHP management. DCS CHP management will triage and track issues presented in the circumvented process and track them through the appropriate internal process as required.

Regulatory Reporting

The Intergovernmental Agreement between AHCCCS and DCS requires DCS CHP to report: Grievances, Appeals and Claim Disputes data related to Medicaid-eligible members on a monthly basis. This information is reported to AHCCCS on the first day of the 2nd month following the month being reported. DCS CHP completes the aforementioned reports in accordance with the instructions provided within the AHCCCS Grievance System Reporting Guide, utilizing the cover letter template and attachments provided by AHCCCS.

Oversight

The MCO is in agreement to report to DCS at its will any and all grievances, appeals and claim disputes data regardless of their outcome. This data will be used as part of DCS oversight for member and MCO compliance with BH/PH according to DCS regulatory guidelines.

REFERENCES

AHCCCS Contractor Operation Manual (AMPM), Chapter 414

AHCCCS Grievance and Appeal System Report

HS-MM-09 Notice of Adverse Benefit Determinations (NOA) Notice of Extension (NOE)

RELATED FORMS

NA

Jason Winfrey
Chief Operations Officer

Date

Karla Mouw
Chief Executive Officer

Date

REVIEWED AND REVISED

Date (Month/Year)	Reason for Review	Revision Description
10/2022	Annual Review	Minor grammar and format changes.