POLICY AND PROCEDURE

DEPARTMENT: Grievance and Appeals	**REFERENCE NUMBER:** AZ.AG.02
EFFECTIVE DATE: 01/30/2013	**POLICY NAME:** Provider Claim Disputes
REVIEWED/REVISED DATE: 09/20/2021, 12/20/2021, 12/19/2022	**RETIRED DATE:** N/A
PRODUCT TYPE: Arizona Medicaid	**PAGE:** 1

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation for its Arizona health plans (the "health plan").

PURPOSE:
To establish a uniform process to promptly identify, review, and resolve provider claim disputes (PCDs) in a manner that is consistent with all federal and state laws, regulations and policies.

POLICY:
Health plan staff are trained to identify and refer PCDs to the Grievance and Appeals (G&A) Department. The G&A Department maintains internal procedures to ensure the prompt resolution of all PCDs in compliance with all governing laws, regulations and policies. All PCDs are adjudicated in Arizona, including those arising from claims processed by an Administrative Services Subcontractor. Provider Claim Disputes are thoroughly investigated using applicable authorities and facts obtained from all parties.

TERMS:
See **Definitions** Section located at the end of this policy.

PROCEDURE:

General Requirements

1. The PCD policy is provided to subcontracted providers and to providers without a contract as follows:
    a. To all subcontractors, (1) at the time of contract; and (2) at the time of any decision to impose a sanction;
    b. To all providers whether contracted or not contracted, at the time of payment, denial, or recoupment of payment on a claim, in whole or in part, via remittance advice no later than 45 days after receipt of a claim for payment;
2. Computation of Time: When a period of time is measured by calendar days, the period of time begins the day after the act, event, or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

3. PCDs involving decisions made by the health plan or its providers are addressed by the health plan. The health plan does not delegate this responsibility.

4. The health plan processes PCDs that are received within the following established timeframes:

    a. For disputes challenging the payment, nonpayment, under- or over-payment, or recoupment of payment on a claim, the dispute must be received no later than 12 months from the ending 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.

    b. For disputes challenging the imposition of a sanction, the dispute must be received within 60 days from the date of receipt of the notice advising that a sanction will be imposed.

5. The health plan has established and notified its providers of the mailing address to be used for PCDs, which is published in the health plan Provider Manual and on all Explanations of Payments (EOPs).

6. All documentation received during the PCD process is date stamped upon receipt.

7. Each PCD is assigned a unique docket number, which is included on all acknowledgement letters, extensions, and notices of decision.

8. PCDs are thoroughly investigated and resolved by applying all applicable statutory, regulatory, contractual, and policy provisions, ensuring that relevant facts are obtained from all parties.

9. All PCD records are filed in secured locations and retained for a minimum of five years after the final decision.

10. PCD Log

    The health plan maintains a log of all PCDs initiated pursuant to this policy. The log contains, at a minimum:

    a. The docket number;

    b. A substantive but concise description of the PCD

c. The following information is recorded in the log:

1) Date of receipt;
2) Nature of claim dispute (case classification)
3) Resolution of claim dispute
4) Date of decision;
5) Date(s) of extension(s), if any;
6) Date of payment of the claim and interest, if applicable; and
7) Date of receipt of any request for state fair hearing, if applicable.
8) Complainant Name
9) Member Name and ID

d. A substantive but concise description of the final decision, the action taken to implement the decision, and the date the action was taken.

11. The Grievance System Administrator has the authority to administer the PCD process and to require corrective action.

Specific Requirements

1. Initiating a Claim Dispute

a. A claim dispute is initiated by sending a written statement to the health plan by fax, e-mail or by regular mail.

b. The health plan requires that a PCD contain the factual and legal basis for the claim dispute and the relief requested. Claim disputes may be denied if the factual or legal basis is not provided.

2. Initial Review and Acknowledgement

a. Upon receipt of a provider claim dispute, the Grievance System Administrator or designee assigns the dispute to a Grievance Specialist for review. The assigned Grievance Specialist does an initial review of the dispute to determine if it was filed with the appropriate health plan. Some provider claim disputes are also managed by the AHCCCS Administration.

If the health plan determines that it is not responsible for processing the PCD, the Grievance Specialist immediately forwards the provider claim dispute to the responsible health plan, or to AHCCCS, with an explanation of why the claim dispute is being forwarded. A copy of the transmittal shall be sent by the health plan to the party filing the claim dispute.

b. If the provider claim dispute is appropriately managed by the health plan, within 5 business days of receipt of a PCD the Grievance Specialist sends written acknowledgment that the claim dispute has been received, will be reviewed, and that a decision will be issued within 30 days of receipt of the claim dispute.

c. Within 30 days of the health plan's receipt of the claim dispute, the health plan issues a written, dated Notice of Decision, which is mailed to the disputing provider at its identified place of business. The Notice of Decision shall include and describe in detail:

(1) The nature of the claim dispute;

(2) The issues involved;

(3) The health plan's decision and the reasons supporting the decision, including references to applicable statutes, rules, applicable contractual provisions, policy and procedures;

(4) If the decision is to uphold the processing of the claim, the provider is advised of their right to request a hearing by filing a written request to the Health Plan no later than 30 days after the date the provider receives the decision;(5) The provider's right to request an informal settlement conference; and

(6) In the event the claim dispute is overturned, the provider is advised that the health plan will reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision. Documentation must be maintained in the claim dispute case file of the timely reprocessing and payment.

3. Extension of time

The 30-day timeframe to issue a decision may be extended with the consent of the parties. An extension must be obtained prior to expiration of the original timeframe and the Grievance Specialist must document in

the file the means and manner by which approval for an extension was obtained from the provider and the Grievance System Administrator.

4. Requests for Administrative Hearing

   a. In the event that the party filing a claim dispute is dissatisfied with the health plan's decision, or if a written Notice of Decision is not received within 30 days after the claim dispute is filed, absent an extension of time, the provider may file a request for a state fair hearing. The request must be filed in writing and received by the health plan within 30 calendar days of the date of receipt of the health plan's decision, or in the event no decision was rendered, within 30 days of the date of filing the claim dispute, absent an extension of time.

   b. When the health plan upholds the denial of a claim dispute and a request for hearing is subsequently filed, the health plan must review the matter to determine why the request for hearing was filed and, if possible, resolve the matter without the necessity of a hearing.

   c. If the matter is not resolved, the Health Plan will forward the request for hearing and supporting documents to the Office of the General Counsel (OGC) within 5 business days of the receipt of the request for hearing. The health plan follows AHCCCS Contractor's Operations Manual Policy 445 for the submission of hearing requests.

5. If the health plan's decision regarding a claim dispute is reversed in full or in part as a result of the appeal process, the health plan reprocesses and pay the claim(s), with interest, when applicable, within 15 business days of the date of the decision unless a different timeframe is specified. Interest is paid as outlined in AHCCCS Contractor Operations Manual Section 203.

REFERENCES:
A.R.S. Title 36, Chapters 5, 29 and 34
A.R.S. Title 41, Chapter 6
A.R.S. § 41-1092 et seq. available here
A.R.S. § 12-901 et seq. available here
2 A.A.C. 7
9 A.A.C. 34, Article 4
AHCCCS Contracts Number YH17-0001-01 Exhibits 14 & 15 and Number and

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YH17-0003-01 (Amended 10/1/16) or a successor contract
AHCCCS Contractors Operations Manual Sections 201 and 445

ATTACHMENTS:

- None

DEFINITIONS:

- ***Claim Dispute:*** A dispute involving a payment of a claim, denial of a claim, or imposition of a sanction.
- ***Day:*** A calendar day unless otherwise specified.
- ***Filed:*** The date on which the claim dispute is received by the health plan.

REVIEW/REVISION LOG

REVISION	DATE
New Policy	01/30/2013
Annual Review; no changes	09/06/2013
Annual Review	08/15/2014
Committee Review	02/16/2015
Annual Review	07/31/2015
Annual Review- updated plan name to include Acute and ALTCS contracts in Arizona	08/16/2016
Added “calendar” to policy	02/24/2017
Ad Hoc Review	05/11/2017
CIC Revision Log: Annual review and revision as follows: Header, Procedure Name: Updated name of policy and procedure to conform to AHCCCS contract – changed from “Claim Dispute” to “Provider Claims Disputes.” Scope: Revised scope of policy to clarify the application of the policy and match current policy template. EMT & CEO approved via email on 08/03/16 Policy: Revised section significantly: Updated references from ADHS to AHCCCS as the entity with which we contract; Added a series of general guidelines from Cenpatico’s contract with AHCCCS as bullet points at the end of Policy section. Terms: removed online link for Definitions and replaced with “at the end of the policy.” Procedure, 3.: Removed the 2nd sentence. Procedure, 6. Made some edits and added a 2nd sentence to Subsection b.	08/03/2016

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Procedure, 9.: Added a 2nd sentence to Subsection a. and made some edits to Subsection b. Procedure, 11.: Added the following to the beginning of Section 11(c)(4): "If the appeal is denied, inform the provider of all applicable mechanisms for resolving the issue external to Cenpatico's internal processes, including" and added Cenpatico to the end of the sentence. In Section 11(c)(5), revised policy to indicate requests for hearing should be directed to Cenpatico for forwarding to AHCCCS in conformance with AHCCCS policy; Procedure. Section 13.: In Section 13b and c updated policy to require internal reconsideration after receipt of a request for hearing; added d. and g. In 13e. added "in full or in part;" changed 1st "administrative hearing" reference to "appeal" and removed other reference before decision. References: Updated References section to remove ADHS contract and related documents and to include AHCCCS contract and related documents and added hyperlinks. Made edits to match current policy template and made some formatting changes.	
CIC Revision Log: Updated formatting and language throughout the policy to be consistent with contractual requirements; Clarified Cenpatico's process for informing contracted and non-contracted providers of Cenpatico's provider claim dispute policy (see General Requirements Section 1); Created new sections to add organization to policy—General Requirements and Specific Requirements; Clarified content of provider claim dispute log (General Requirements Section 10); Added fax number and email address as permissible methods for filing a dispute (Specific Requirements Section 1); Updated policy to include process for initial review of a provider claim dispute (Specific Requirements Section 2); Updated policy to add specificity to the extension process (Specific Requirements Section 3); Added cross-reference to AHCCCS policy on interest payments (Specific Requirements Section 5)	07/24/2017
Complete rewrite of AZ.GA.02 with adoption of language from CAZ.MA.GA.001 • Policy updated to apply to all Medicaid health plans;	05/21/2018

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• Policy statement updated for clarity; • Defined Provider Claim Dispute with the acronym "PCD" and used the acronym throughout the policy; • Removed some specific language about the address of filing to allow for changes that may occur during the Complete Care Contract; and • Removed specifics regarding transmission of file for State Fair Hearing and instead referred to ACOM Policy for specifics.	
Updates made to Policy section on page 1 to added investigated facts	05/28/2019
Updates made to the established timeframes for disputes	05/15/2020
Updates made to the information maintained in the PCD log. Updates made to the timelines for requesting a hearing and the process for forwarding hearing requests to OALS.	08/13/2020
Annual Review.	09/20/2021
Office of Administrative Legal Services (OALS) renamed to Office of the General Counsel (OGC)	12/20/2021
Annual Review. Updated elements required in PCD log.	12/19/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.