

SECTION VIII: Claim Disputes and Appeals

PROVIDER CLAIM DISPUTES & APPEALS

Care1st encourages providers to check claim status on our website www.care1staz.com or contact Claims Customer Service for assistance with questions or issues regarding claim payment, partial payment, or non-payment. As a reminder, initial claim submissions must be received within six months from the date of service. A claim may be disputed by filing a claim dispute.

A Claim Dispute is:

1. a formal legal challenge of a health plan's disposition of a claim
2. a time sensitive process that is without exception

A Claim Dispute is not:

1. an alternate claim submission or resubmission process
2. a billing and or write-off requirement
3. a means for a contracted provider to seek an exception of claims rules

AHCCCS guidelines require that all claim disputes (i.e. complete or partial denial of a claim) be submitted in writing within 12 months from the date of service; within 12 months after the date of eligibility posting; the date of discharge (for an inpatient claim); or within 60 days of the last adverse action, whichever is greater. A provider should never wait longer than the required timeframes to file a dispute: however, **providers are encouraged to exhaust all available means of resolving an issue before filing a dispute.**

All requests for dispute should include:

1. A completed claim dispute form OR a letter detailing the factual and legal basis for the dispute. (Please submit one Claim Dispute Form or a letter for each disputed claim. The Claim Dispute Form is available on our website in the "Forms" section of the Provider menu or by contacting Network Management).
2. A copy of the original claim and remittance advice
3. Supporting documentation for reconsideration. For provider disputes with a clinical component (such as denied inpatient days, or services denied for no prior authorization), additional documentation should include a narrative describing the situation, an operative report and medical records as applicable.
4. **Mail** the completed form(s) and documentation to:

**Care1st Provider Claim Disputes
1850 W Rio Salado Parkway, Suite 211
Tempe, AZ 85281**

Note: Disputes that fail to detail the facts of the case, the legal argument or are submitted with incomplete information will be denied without medical review. Care1st will not attempt to solicit supporting documentation.

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PROCEDURE

- Care1st acknowledges claim dispute requests within five business days of receipt. If you do not receive an acknowledgement letter you should contact the Claim Disputes & Appeals Team to inquire about the status of the matter immediately.
- Disputes are reviewed and a decision issued within 30 calendar days of receipt. Care1st may request an extension of up to 14 calendar days, if a need for additional information is established.
- Care1st issues ALL decisions, whether approved or denied, in writing.

If a provider disagrees with the resolution of a matter, a request for State Fair Hearing may be filed in writing, and within 30 days from the date of receipt of the Care1st decision letter. The process for requesting a hearing will be provided in the decision letter. When a request for State Fair Hearing is received, the plan will copy the case file and forward it to the AHCCCS Office of Administrative Legal Services (OALS) who will either schedule an administrative hearing or render an “*informal decision*”. The provider will be notified by the AHCCCS Office of Administrative Legal Services of hearing dates, times and locations. AHCCCS administrative hearings are conducted by an Administrative Law Judge at the Office of Administrative Hearings. At the conclusion of the hearing, the Administrative Law Judge will issue a recommended decision to the AHCCCS Administration, AHCCCS Administration issues a final determination.

MEMBER APPEALS

A provider may appeal on behalf of a member with the member’s written consent or may direct the member to the Customer Service Department for appeal submission.

Members may appeal telephonically, in person, or in writing within 60 days of the notice of adverse action. Expedited Member Appeals are resolved within 72 hours while standard appeals are resolved in 30 days. An extension of up to 14 days may be taken for either expedited or standard appeals, if required to fully investigate the matter.

All Member Appeals are mailed to:

**Care1st
Member Appeals
1850 W Rio Salado Parkway, Suite 211
Tempe, AZ 85281**

Note: All claim disputes and appeals are tracked for trends, however no action is ever taken against a provider who files a claim dispute, supports an enrollee’s appeal or advocates on behalf of the member.