Chapter 10

PROVIDER CLAIMS DISPUTES AND MEMBER APPEAL

The federal government, the State of Arizona, and the AHCCCS Administration have established laws, rules, policies and procedures that determine how CMDP processes and adjudicates appeals. The rules associated with appeals include 42 CFR 438 Subpart F, Arizona Revised Statutes (A.R.S.) Section 36 and Arizona Administrative Code (A.A.C) Title 9, Chapter 34.

Grievances

A grievance is a member's expression of dissatisfaction with any aspect of his/her care, other than the appeal of an *action*. (Action is defined in the Member Appeals section on pages 10-2, 3 of this chapter.) Grievances include, but are not limited to, the quality of care or services provided, rudeness of a provider or CMDP staff, or failure to respect a member's rights.

How to File a Grievance

- A member may file a grievance at any time either orally or in writing to CMDP.
- A disposition will be completed and provided no later than 90 days after receipt of the grievance.

Provider Claim Disputes

When inquiring about the status of a claim, please note the following information:

- Please allow 30 days following claim submission before making an inquiry, and do not exceed 6 months from the date of service.
- If a claim is pending in the CMDP claims processing system, a claim dispute will not be investigated until the claim is paid or denied, or is over 3 months from the receive date.
- Review Provider Remittance Advice (RA) for the claim in question.
    - If the RA has not been received or status is unknown, contact the CMDP Claims Unit at (602) 351-2245 or (800) 201-1795 to determine whether the claim has been received and processed.

Prior to submitting a claim dispute, CMDP encourages all providers to contact the Claims Unit or Provider Services for assistance in resolving disputes.

All claim disputes submitted to CMDP are investigated using applicable statutory, regulatory, contractual, and policy provisions.

How to File a Claims Dispute

The following information can also be found at the bottom of all RA. Submit a claim dispute in writing to CMDP via mail or fax to:

Arizona Dept. of Child Safety
CMDP Site Code C010-18
Attn: Dispute and Appeal Manager
P.O. Box 29202

Phoenix, Arizona 85038-9202
Fax (602) 264-3801

- All claim disputes challenging claim payments or adjudication must be submitted within 12 months from the date of service or within 60 days after the date of the payment, denial, or recoupment of a timely claim submission, whichever is later.
- State, in detail, the factual and legal basis for the dispute and the relief requested (e.g., additional payment, reversal of claim denial).
- Be sure to provide any and all relevant supporting documentation, including a clean claim.

Upon Receipt of Your Claim Dispute

- CMDP sends a letter of acknowledgement to the provider within 5 business days of receipt. The provider should retain this letter for reference.
- A *Notice of Decision* is communicated within 30 days after the date the dispute was received, unless an extension of time has been agreed upon.
- If it is determined that the original claim denial was CMDP's error, the claim is forwarded to the CMDP Claims unit for processing. It is not necessary for the provider to re-submit the claim.
- Overturning a claim dispute does not constitute a guarantee of payment nor does it constitute a waiver of all claim filing requirements and conditions.
- Claims are subject to all routine claims processing edits and audits.
- If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied or an edit may fail, even though the claim dispute was overturned for other reasons.
- If a provider disagrees with the outcome of the claim dispute, a provider is allowed to request a State Fair Hearing.
- The request must be submitted to CMDP no later than 30 days after the date of receipt of the *Notice of Decision*.
- All information concerning the issue will be sent to the AHCCCS Office of Administrative Legal Services (OALS) for a hearing.
- Submit requests for hearing to the address below:

Arizona Dept. of Child Safety
CMDP, Site Code C010-18
Attn: Dispute and Appeal Manager
P.O. Box 29202
Phoenix, Arizona 85038-9202

Member Appeals

CMDP provides written responses to members or their authorized representatives regarding authorization denials, reductions, suspensions, or terminations of services. A denial of an authorization is called a *Notice of Adverse Benefit Determination* or a *Notice of Action*, and often referred to simply as an *Action*.

An *action* is defined as:

- Denial or limited authorization of a requested service, including the type or level of services;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment of a service;
- Failure to provide services in a timely manner as set forth in contract;
- Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or,
- For a member residing in a rural area, denial of the member's right to obtain services outside the network.

Members may file an appeal of any CMDP action.

CMDP has no dispute/appeal policies that prevent providers from advocating on behalf of its members as defined under 42 CFR 438.102. A provider may file an appeal on behalf of a member with the written consent of the member's authorized representative (i.e., the custodial agency representative or juvenile justice representative).

If the provider attests that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or retain maximum function, an expedited appeal may be filed. Expedited appeals are resolved as the member's health condition requires, and no later than 3 business days following the receipt.

Member appeal determinations are made by individuals not involved with initial review or previous decision-making. Any higher level review involving clinical determinations are always conducted by health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the member's condition or disease.

How to File a Member Appeal

- Appeals can be filed either orally or in writing within 60 days of the Notice of Action. If you have any questions or require assistance, please contact the CMDP Dispute and Appeal Manager.
    - If you have any questions or require assistance, please contact the CMDP Dispute and Appeal Manager.
- CMDP issues a *Notice of Appeal Resolution* within 30 days for a standard appeal or no later than 3 business days for an expedited appeal, unless the requestor and CMDP have agreed upon an extension of up to 14 days.
- The decision timeframe is calculated from the date the appeal is received by the CMDP Dispute and Appeal Manager.
- The member or authorized representative may request continuation of services while the appeal is pending. The services will continue if:
    - The appeal is filed timely;
    - The appeal involves the termination, suspension, or reduction of previously authorized services;
    - Services were authorized by CMDP;
    - Original period covered by original authorization has not expired; and
    - The member requests and CMDP approves that services continue.
- A request for continuation of services must be filed within 10 days from the date CMDP mails

the *Notice of Action*.

- A member or provider may request a State Fair Hearing if the member/provider disagrees with the CMDP member appeal decision.
- A provider cannot file a member appeal without written consent from the legal guardian (DCS Specialist).
- The request must be in writing to CMDP no later than 30 days after receiving the *Notice of Appeal Resolution*.
- AHCCCS Administration notifies CMDP and the requestor of the time, place, and nature of the hearing.