CHAPTER 15:

Claim Disputes, Member Appeals and Member Grievances

Reviewed/Revised: 9/15/24, 01/01/24

15.0 OVERVIEW

Disputes are resolved through the BCBSAZ grievance process in compliance with Arizona state law (ARS §§ 20-3101 and 20-3102). Contracted and non-contracted providers may initiate the process by sending BCBSAZ a written request.

Disputes/Grievance issues may include but are not limited to:

- Whether a claim was clean
- Timely filing
- 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
- COB issues
- Coinsurance/deductible
- 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

15.1 ALTERNATIVE TO FILING A DISPUTE (FIRST STEPS TO CONSIDER BEFORE FILING A DISPUTE)

Claim Reconsideration

If your claim has denied for additional information *(i.e. missing medical records, missing an IZ form, etc.)* or corrections (*invalid CPT code, invalid place of service, etc.),* it is considered a Reconsideration. Claim reconsideration should be sent to the Plan via the Claims Department for reconsideration with a stamp or legible notice indicating the claim is a "Reconsideration". If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim. Please refer to the BCBSAZ Health Choice Provider Manual Chapter specific to your claim form type for further instruction on how to resubmit claims.

Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the corrected claim form with the services listed in detail. All claim reconsiderations should be mailed to:

ACA StandardHealth with Health Choice
Attn: Claims Department - Reconsiderations
8220 N. 23rd Ave.
Phoenix, AZ 85021

All providers have the right to file a claim dispute in response to any adverse action or determination made by BCBSAZ Health Choice. However, BCBSAZ Health Choice encourages providers to exhaust all other means of resolution before using the claim dispute process. Potential options prior to filing a claim dispute are:

- **Provider Portal**: The Provider Portal offers many features including claim reconsideration submissions, claim dispute, claim(s) status checks, EOB, member eligibility inquiry and member rosters. This tool puts the control in the provider's hands and allows staff the opportunity to status claims on their time without waiting on hold.

- **Claims Customer Service**: The Claims Customer Service line is a group of dedicated personnel trained to answer questions about claims and status claims for the provider. Providers may contact BCBSAZ Health Choice Claims Resolution Services Unit at (800) 322-8670 to resolve claims reimbursement issues informally. The Claims Resolution Services Unit provides assistance with claim issues including denied claims and incorrectly paid claims. Providers and office staff may also contact Claims Resolution Services to discuss questions about a remittance advice and/or to check the status of a claim.

- **Electronic Explanation of Benefits (EOB/835)**: The electronic EOB or electronic remittance advice (sometimes referred to as the ERA or 835) is a more automated way of posting payments from the EOB that can be directly inputted into your practice management system. Contact your clearinghouse or practice management software vendor to see if you have this capability.

15.2 FILING A CLAIM DISPUTE (FOR PROVIDERS)

TIMEFRAMES FOR INITIATING CLAIM DISPUTE

The claim dispute must be filed within the timeframes as provided within the grid below. BCBSAZ Health Choice may extend time period for good cause or if a longer period is required by state or federal law.

Timeliness	NON-CONTRACTED (NSA Qualifying Claims Only)	CONTRACTED
Claim Submissions	12 Months from the DOS	6 Months from DOS
Claim Re-submission	12 Months from the processing date of the original claim Submission	12 Months from DOS
Dispute	30 Business days to ask for open negotiation	**Disputes related to coverage, benefit book exclusions, medical necessity, non-contracted claim denials** Within 2 years from date of denial (there is only one level of internal appeal) **Payment disputes (Services are covered, provider believes the services weren't reimbursed correctly/underpaid)** One year after denial or other notification, or date of the occurrence if the provider did not receive notification (level one, internal appeal)
Second Level Dispute	After open negotiation, 4 business days to seek Federal IDR	**Disputes related to coverage, benefit book exclusions, medical necessity, non-contracted claim denials** Up to 4 months from date of final internal adverse determination (external) **Payment disputes (Services are covered, provider believes the services weren't reimbursed correctly/underpaid)** Within 60 days of Provider's receipt of Level 1 decision (level two, internal appeal)

Please include the following items with the written claim dispute:

- A separate cover letter for each claim being disputed.
  The cover letter must include: The member's information
    a. Member's Name
    b. Member's Identification Number
    c. Date of Service
    d. Claim Number being disputed
- A reference to, or copy of, the action with which the provider disagrees.
- A written explanation of why the provider thinks the action is wrong, and the relief the provider is requesting.
- All necessary documentation that supports the provider's position, such as medical records, operative reports, or office notes.

Mail the dispute directly to:

ACA StandardHealth with Health Choice
Attention: Claim Dispute Department
8220 N. 23rd Ave.
Phoenix, AZ 85021

Once BCBSAZ Health Choice receives the dispute, BCBSAZ Health Choice will send an acknowledgment letter via USPS regular mail within five (5) business days from the date of dispute receipt.

BCBSAZ Health Choice shall issue a written, dated decision (Notice of Decision) which will be mailed within 30 days after the provider files a claim dispute with BCBSAZ Health Choice, unless the provider and BCBSAZ Health Choice have agreed to a longer period. The decision will include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved;
- BCBSAZ Health Choice's decision and the reasons supporting the decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedures;
- The provider's right to request a second level review if the provider is dissatisfied with the first-level grievance resolution. The second-level dispute/grievance must be submitted in writing within 60 calendar days after the receipt of the first-level determination.

EXTENSION OF TIME
In some cases, BCBSAZ Health Choice may need more time in order to research a claim disputes. If an extended time period is needed, BCBSAZ Health Choice will provide notification of the extended timeframe (as long as it does not unreasonably postpone the final resolution of the matter). The extended time frame will not exceed 60 days, and BCBSAZ Health Choice will notify the provider in writing of the extension." Documentation of the agreement to the extension of time must be maintained in the claim dispute case record.

If you have any questions regarding your dispute, you may contact the Appeals and Dispute Department at (480) 968-6866.

OTHER GENERAL REQUIREMENTS RELATED TO CLAIM DISPUTES
Computation of Time - A written claim dispute is considered filed when it is received by BCBSAZ Health Choice by a date stamp or other record of receipt. Providers must use the following methodology in computing any period of time described in this chapter:

- Computation of time for calendar day 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.

BCBSAZ Health Choice will utilize a unique tracking number for each claim dispute filed. Providers must utilize the BCBSAZ Health Choice assigned tracking number when contacting BCBSAZ Health Choice regarding their dispute.

All documentation received during the claim dispute resolution process is date stamped upon receipt.

All claim dispute case records are filed in secured locations and retained for five years after the most recent decision has been rendered.

All decisions shall be personally delivered or mailed to the party at their last known residence or place of business.

15.3 MEMBER GRIEVANCES AND APPEALS

BCBSAZ Health Choice member dispute process covers Standardhealth with Health Choice member appeals and member grievances as defined below.

Member appeal – definition
A member appeal is an oral or written request by a member, a provider acting on behalf of a member, or a member's authorized representative to challenge a BCBSAZ Health Choice decision to deny a request for prior authorization or a claim for services already provided.

Member grievance – definition
A member grievance is a dispute about how BCBSAZ applied the member cost share, such as copayment, deductible, coinsurance, and level of benefits.

Issues that can be appealed or grieved
Below is a summary of issues that can be disputed through the BCBSAZ Health Choice member appeal and grievance processes.
When BCBSAZ Health Choice:

- Denies a request for preauthorization of a service not yet received
- Denies a claim for services already received
- Denies, reduces, or terminates the member's plan benefits
- Fails to provide or pay for a benefit covered under the member's plan
- Finds the member ineligible for a benefit under his or her plan
- Finds the member responsible for payment of cost share (copay, deductible, coinsurance, access fee, balance bill) for a plan benefit
- Finds that a service is not medically necessary
- Finds that a service is not covered because it is experimental or investigational
- Determines that the member is not eligible for coverage under the benefit plan

- Rescinds the member's coverage under the plan
- Fails to correctly process an out-of-network claim under the federal No Surprises Act (NSA) when the claim is in-scope for the NSA
- Additional information regarding the No Suprises Act can be found at the following link; Claims & Remits | No Surprises Act | BCBSAZ (azblue.com)

15.3.1 MEMBER APPEALS

Member may file an appeal with BCBSAZ Health Choice in response to an action.
Action means:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
- Denial of a rural member's request to obtain services outside the Contractor's network when the contractor is the only Contractor in the rural area.

Most member appeals are the result of a denied request for a service (current/future) that the member believes should be approved by the Plan. Please refer to Chapter 6 Authorizations and Notifications for details. If BCBSAZ Health Choice fails to render a decision on an authorization within the required time (as outlined in Chapter 6), then the member may consider the request "denied" and he/she can file an appeal.

When BCBSAZ Health Choice denies a request for authorization, a *Notice of Adverse Benefit Determination (NOA)* is mailed to the member, and an explanation letter is mailed to the requesting provider. The member's NOA will advise the member on their appeal rights.

If BCBSAZ Health Choice reduces, suspends or terminates an existing service, the member may request for a continuation of services during the appeal process. Details regarding the continuation of services are available in the Member Handbook on the BCBSAZ Health Choice website at https://www.standardhealthhc.com, or through our Member Services Department.

15.3.2 HOW A MEMBER FILES AN APPEAL

We have a defined appeal/grievance process for members and their treating providers. However, some large, self-funded employer groups have benefit plans that require additional regulatory procedures and may have customized timelines and other protocols that deviate from the process used for most BCBSAZ members.
The specific dispute processes are explained in the appeal/grievance packet, which also includes all related forms. For most member disputes, providers will use one of two "standard" appeal packets available online at Provider | Resources |Appeals and Grievances | AZBlue

Most members file their appeals themselves. Even in this case, before we make our decision, we will ask the requesting provider for additional information to assist us in our determination of the Appeal.

Documentation to include when supporting a BCBSAZ member appeal/grievance
To enable us to timely and accurately respond to an appeal/grievance, providers should include the following information:

- A reference to the action or copy of the decision notice that is being appealed
- A written explanation of why the action may be incorrect, and the relief requested
- Documentation that disputed services meet the clinical criteria or pharmacy coverage guidelines − Clinical criteria are available on the BCBSAZ Health Choice website
- Pharmacy coverage guidelines are available at azblue.com/Pharmacy
- All other documentation that supports the appeal, such as medical records, operative reports, and office notes

The provider and member are responsible for sending all relevant information to support a dispute and show why we should change our original decision. We do not solicit records to support an appeal/grievance. If the provider or member does not provide documentation, we will make the decision using only the information we already have.

However, if waiting 30 days for a decision could seriously jeopardize the members' life, health or the ability to attain, maintain or regain maximum function, the member, or the member's physician, can request an Expedited Appeal. In these instances the appeal will be decided within 1 business day or 72 hours, whichever is shorter, of receiving the appeal.
Members may request an expedited request for hearing in the event the expedited appeal is downgraded to a standard appeal.

An extension, up to 14 additional calendar days, can be requested by the member or BCBSAZ Health Choice, if the extension is in the member's best interest.

For appeals not resolved wholly in favor of the appellant, BCBSAZ Health Choice shall advise the appellant in writing of their right to request an External Review with the Arizona Department of Insurance and Financial Institutions (DIFI) or an Independent Review Organization (IRO).