CHAPTER 15:

Claim Disputes, Member Appeals and Member Grievances

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15.0 DEFINITIONS

Claim Dispute: As defined in A.A.C.R9-34-402 (B) means, "a dispute involving a payment of claim, denial of claim, imposition of a sanction or reinsurance."

Member Appeal: A request for review of an action (see definition of "Action").

Action: The definition of action [per 42 CFR 438.400(b)] is the:

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner;
5. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
6. Denial of a rural member's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

Member Grievance: Dissatisfaction with any aspect of their care (other than the appeal of actions).

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 7 and specific chapter 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:

Health Choice Arizona
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(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. *The provider portal allows for up to two reconsiderations and one formal dispute per claim.
- **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 CLAIM DISPUTE AND STATE FAIR HEARING PROCESS (FOR PROVIDERS)

BCBSAZ Health Choice processes provider Claim Disputes and State Fair Hearings in accordance with established law, rules, and procedures set forth by AHCCCS (A.R.S. §36-2903.01 and A.A.C. R9-34-401 et seq.

15.2.1 FILING A CLAIM DISPUTE

The (hereinafter “provider”) claim dispute process affords providers the opportunity to challenge a decision by BCBSAZ Health Choice for issues involving:

- A payment of a claim;
- The denial of a claim;
- The recoupment of payment of a claim; and

- The imposition of sanctions.

Providers will initially file a claim dispute directly with either BCBSAZ Health Choice or AHCCCS, depending upon:

- Which entity is responsible for the decision; and/or
- If a claim payment issue, the dispute involves a claim for services submitted to BCBSAZ Health Choice for a person enrolled with BCBSAZ Health Choice.

Providers initially submit a claim dispute to BCBSAZ Health Choice when:

- Challenging a decision of BCBSAZ Health Choice; or
- Disputing a claim payment issue for services provided to persons enrolled with BCBSAZ Health Choice.

Once BCBSAZ Health Choice makes a decision regarding a provider claim dispute, the provider may request another review of the decision, referred to as a State Fair Hearing. Many times, disagreements between a provider and BCBSAZ Health Choice can be resolved through an informal process. Providers are encouraged to resolve issues at the informal level before initiating the formal provider claim dispute process. Please note that the formal claim dispute process contains very specific timeframes within which to file for a review and/or hearing. Attempts to resolve issues through the informal process does not suspend or postpone formal claim dispute timeframes.

The intent of this chapter is to describe the options available to providers to resolve issues and other events related to a decision of BCBSAZ Health Choice. The chapter is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of BCBSAZ Health Choice; and
- The process for requesting a State Fair Hearing in the event a provider does not agree with the claim dispute decision of BCBSAZ Health Choice.

TIMEFRAMES FOR INITIATING CLAIM DISPUTE

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the date of notice advising that a sanction will be imposed, or
- For challenges to the payment, denial or recoupment of a claim, the later of the following:
    - 12 months of the date of delivery of the service;
    - 12 months after the date of eligibility posting; or
    - Within 60 days after the payment or denial of a timely claim submission, or the recoupment of payment, whichever is later.

Please note, per A.R.S. 36-2904(G.3) "Submitted" means the date the **claim** is **received** by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt. This means that the provider

must provide proof that BCBSAZ Health Choice received your claim such as a tracking number or certified mailing card.
Disputes received outside of AHCCCS regulatory guidelines will be denied as untimely. BCBSAZ Health Choice will not address the merits of the dispute.
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
  2. Details of the factual and legal basis for the dispute
  3. The name and contact information of the individual filing the dispute
  4. The provider's or facility's fax number

- A copy of the claim
- Applicable documentation to support your position which may include, but is not limited to:
  1. Medical records
  2. Phone calls or other Plan correspondence received regarding the processing of the claim
  3. Reference materials (such as policies, medical standards, or coding information)
  4. Explanation of Benefits (EOB) from primary payor(s) (if applicable)

Mail the dispute directly to:

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

Submit the dispute directly from within the secure Provider Portal:
Log in - Health Choice Provider Portal (healthchoiceaz.com)

Fax the dispute directly to 480-760-4771

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 must 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 hearing by filing a written request for hearing to AHCCCS no later than 30 days after the date the provider receives BCBSAZ Health Choice´s decision;
- The provider's right to request an informal settlement conference prior to hearing; and
- If the claim dispute is overturned, the requirement that BCBSAZ Health Choice must reprocess and pay the claim(s), with interest, when applicable, in a manner consistent with the Decision within 15 business days of the date of the decision.

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 30 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 FILING A REQUEST FOR STATE FAIR HEARING (FOR BOTH MEDICAL AND BEHAVIORAL HEALTH CLAIMS)

15.3.1 REQUESTS FOR ADMINISTRATIVE HEARING (CLAIM DISPUTES)

If you are not satisfied with the claim dispute decision (also referred to as a Notice of Decision), you may submit a *Request for State Fair Hearing*.

BCBSAZ Health Choice does not have a second level dispute process. Please make sure that your request indicates "Request for State Fair Hearing", or your correspondence may be considered a duplicate dispute, or returned.

15.3.2 REQUIREMENTS FOR A REQUEST FOR STATE FAIR HEARING

The request for an administrative hearing to AHCCCS must include:

- Provider name, AHCCCS Identification Number, address, phone number and the AHCCCS docket number;
- Member's name and AHCCCS identification number;
- Provider's Name, address, AHCCCS Identification Number and phone number (if applicable);
- The date of receipt of the claim dispute;
- The issue to be determined at the administrative hearing; and
- A summary of BCBSAZ Health Choice actions undertaken to resolve the claim dispute and basis of the determination.

15.3.3 TIMEFRAMES FOR REQUESTING A STATE FAIR HEARING

The provider's request for a hearing must be filed in writing and received by the Plan no later than 30 calendar days of the date of receipt of the BCBSAZ Health Choice Notice of Decision, absent of an extension of time. A written request for hearing is considered filed when received by AHCCCS Office of Administrative and Legal Services (OALS) established by a date stamp or other record of receipt.

BCBSAZ Health Choice will forward a copy of the Request for State Fair Hearing along with the claim dispute file to the AHCCCS Office of Administrative Legal Services within five (5) business days from the date of the Hearing Request receipt. AHCCCS is responsible for scheduling the hearing and will notify both the provider and BCBSAZ Health Choice of the appointed date and time of the hearing.

Hearings are held at the Office of Administrative Hearings (OAH)

Additional information regarding the State Fair Hearing process may be found on the Frequently Asked Questions page on the OAH website at: http://www.azoah.com.

Motions regarding, or requests to withdraw hearings, must be in writing and sent to OAH and to BCBSAZ Health Choice. Motions regarding your hearing, or withdrawal requests may be sent to OAH via facsimile at (602) 542-9827, or electronically through the Motions page located on their website. Motions or withdrawal requests sent to BCBSAZ Health Choice may be mailed, included in the electronic motion (by including the e-mail address of the intended recipient), or faxed to (480) 760-4771.

15.3.4 SCHEDULING OF AN ADMINISTRATIVE HEARING

Pursuant to A.R.S. § 41-1092.03, upon receipt of a request for hearing, the AHCCCS Office of Administrative Legal Services (OALS) schedules an administrative hearing pursuant to A.R.S. § 41-1092.05

AHCCCS OALS shall accept a written request for withdrawal from the filing party if the request is received prior to AHCCCS scheduling and mailing the Notice of Hearing. Otherwise, a filing party who wishes to withdraw must send a written request (motion) for withdrawal to the Office of Administrative Hearings consistent with A.A.C.R2-19-106(A)(3).

If AHCCCS or BCBSAZ Health Choice decision regarding a claim dispute is reversed through the claim dispute or hearing process, AHCCCS or BCBSAZ Health Choice shall reprocess and pay the claim(s) with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.

15.3.5 ADMINISTRATIVE PROCESS

The Administrative Hearing Process shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.

15.4 NOTICES TO MEMBERS (NOTICE OF ADVERSE BENEFIT DETERMINATION)

15.4.1 GENERAL INFORMATION

Language and Format Requirements

Entities responsible for sending notice to Title XIX/XXI eligible persons must ensure that:

- Notice and written documents related to the appeals process must be available in each prevalent, non-English language spoken within BCBSAZ Health Choice's Geographic Service Area;
- As applicable, providers must provide free oral interpretation services to explain information contained in the notice or as part of the appeal process for all non-English languages;
- Notice and written documents related to the appeals process must be available in

alternative formats, such as Braille, large font or enhanced audio and take into consideration the special communication needs of the person; and
- Notice and written documents must be written using an easily understood language and format.

Delivery of Notices
All notices identified herein, including those provided during the appeal process, shall be delivered in person or mailed to the required party, including the Title XIX/XXI eligible person and, when applicable, their legal representative or designated representative (e.g., Department of Child Safety and/or advocate for SMI persons requiring special assistance) at their last known residence or place of business.

For Title XIX/XXI eligible persons under the age of 18, the Notice of Adverse Benefit Determination must be delivered to their legal or custodial parent or a government agency with legal custody of the Title XIX/XXI eligible person.

In the event that it may be unsafe to contact the person at his or her home address, or the person has indicated that he or she does not want to receive mail at home, the alternate methods identified by the individual for communicating notices shall be used.

Prohibition of Punitive Action
Providers must not take punitive action against a Title XIX/XXI eligible person who decides to exercise their right to appeal. BCBSAZ Health Choice does not take punitive action against a provider who requests an expedited resolution to an appeal or who supports a Title XIX/XXI eligible person's appeal.

15.4.2 NOTICE OF ADVERSE BENEFIT DETERMINATION (TITLE XIX/XXI COVERED SERVICES)

For Title XIX/XXI covered services, notice must be provided following:
- 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 that is not TITLE XIX/XXI covered; and
- The denial of the Title XIX/XXI person's request to obtain services outside the network.

Responsibility for Sending the Notice of Adverse Benefit Determination
For prior authorized services, BCBSAZ Health Choice ensures the communication of a notice to the member.
AHCCCS requires notice to Title XIX/XXI eligible persons enrolled with a Tribal RBHA (TRBHA) following:

- The denial or limited authorization of a requested service, including the type or level of service (see Chapter 6 Authorizations and Notifications); and
- The reduction, suspension or termination of a previously authorized service.
- AHCCCS sends notices to Title XIX/XXI eligible persons who have been adversely affected by a Pre-Admission Screening and Resident Review (PASRR) determination in the context of either a preadmission screening or a resident review.

Communication of Notice to Title XIX/XXI Eligible Persons

The use of a **Notice of Adverse Benefit Determination** is required when providing notice regarding an action concerning a Title XIX/XXI person. (Please see the **AHCCCS Contractors Operations Manual (ACOM) 414 NOA and NOE for Service Authorizations** for guidance in preparation of this form). **Notice of Adverse Benefit Determination** will include the following:

- The requested service;
- The reason/purpose of that request in layperson terms;
- The action taken or intended to be taken (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
- When denying, reducing or terminating a service for a Title XIX member who is under the age of 21, the Notice of Adverse Benefit Determination must cite AHCCCS EPSDT Rule A.A.C. R9.22.213 and Federal Law 42 USC 1396d(r)(5).
- The effective date of the action;
- The reason for the action, including member specific facts;
- The legal basis for the action;
- An explanation of the action and of the legal basis, provided in easily understood language;
- Where members can find copies of the legal basis (the local public library and the web page with links to legal authorities; when a legal authority or an internal reference to the Contractor's policy manual is available on-line, the Contractor shall provide the accurate URL site to enable the member to find the reference on-line);
- The right to and process for appealing the decision;
- A statement notifying the member that BCBSAZ Health Choice will provide reasonable assistance to a person seeking to file an appeal, including the mailing address and phone number of the BCBSAZ Health Choice Appeals Department; and
- Legal resources for members for help with appeals, as prescribed by the Arizona Health Care Cost Containment System (AHCCCS) (See AHCCCS Contractors Operations Manual).

It is unacceptable to cite lack of medical necessity as a reason for denial, without an explanation of why the service is not medically necessary. Failure to provide a reason for an action will result in regulatory action by AHCCCS, including but not limited to sanction per event (notice) and/or capping of enrollment. Refer to Section II of the Guide for examples where medical necessity is

appropriately used in denying/limiting services. NOAs that do not explain why the service has been denied/reduced and merely refer the member to a third person for more information are unacceptable. The NOA must state the reasons supporting the denial/reduction. The Contractor may include a statement referring a member to a third person for more help when the third person can explain treatment alternative in more detail.

NOTICE OF ADVERSE BENEFIT DETERMINATION TIMEFRAMES

Notice of Adverse Benefit Determination for Service Authorization Requests

For service authorization requests, the following timeframes for sending notice of action are in effect (see Chapter 6: Authorizations and Notifications for required timeframes for decisions regarding prior authorization requests):

- For an authorization decision related to a service requested by or on behalf of a Title XIX/XXI eligible person, the responsible entity must send a notice of adverse benefit determination within 14 days following the receipt of the person's request;
- For an authorization request in which the provider indicates, or the responsible entity determines, that the 14 calendar day timeframe could seriously jeopardize the person's life or health or ability to attain, maintain or regain maximum function, the responsible entity must make an expedited authorization decision and send the Notice of Adverse Benefit Determination as expeditiously as the person's health condition requires, but no later than 72 hours after receipt of the request for service.
- If BCBSAZ Health Choice denies a request for expedited service authorization decision, and the requested service is not of an urgent medical nature, the expedited request may be downgraded to a standard request. BCBSAZ Health Choice will notify the requesting provider of the downgrade and the requesting provider will have an opportunity to disagree. The requesting provider may send additional documentation supporting the need for an expedited authorization.
- If the Title XIX/XXI eligible person requests an extension of either timeframe above, the responsible entity must extend the timeframe up to an additional 14 days;
- If the responsible entity needs additional information and the extension is in the best interest of the person, the responsible entity shall extend the 14-calendar day or the three working day timeframe up to an additional 14 days. If the responsible entity extends the timeframe, the responsible entity must:
- Give the Title XIX/XXI eligible person written notice of the reason for the decision to extend the timeframe using Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Services, and inform the person of the right to file a complaint if the person disagrees with the decision; and
- Issue and carry out the determination as expeditiously as the person's condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the maximum timeframes outlined above, the authorization shall be considered denied on the date that the timeframe expires.
- AHCCCS or BCBSAZ Health Choice, shall provide the requesting provider written notification of a decision to deny a service authorization.

Notice of Adverse Benefit Determination for Service Termination, Suspension or Reduction
For service terminations, suspensions or reductions, the following timeframes are in effect:

- The responsible entity must send the Notice of Adverse Benefit Determination at least 10 days before the date of the action with the following exceptions. The responsible entity may send the Notice of Adverse Benefit Determination no later than the date of the action if:
  - The responsible entity has factual information confirming the death of a Title XIX/XXI person;
  - The responsible entity receives a clear written statement signed by the Title XIX/XXI person or their legal representative that the person no longer wants services or gives information to the responsible entity that requires termination or reduction of services and indicates that the person understands that this will be the result of supplying that information;
  - The Title XIX/XXI person is an inmate of a public institution that does not receive federal financial participation and the person becomes ineligible for TXIX/XXI;
  - The Title XIX/XXI person's whereabouts are unknown and the post office returns mail to the responsible entity indicating no forwarding address;
  - The responsible entity establishes the fact that the Title XIX/XXI person has been accepted for Medicaid by another state. The responsible entity may shorten the period of advance notice to five (5) days before the date of action if the responsible entity has verified facts indicating probable fraud, waste or program abuse by the Title XIX/XXI eligible person; or
  - AHCCCS or BCBSAZ Health Choice may shorten the period of advance Notice of Action to five (5) working days before the date of action if there are verified facts indicating probable fraud by the Title XIX/XXI eligible member.;

15.5 MEMBER GRIEVANCES AND APPEALS

On occasion, a member may ask you how to file an appeal or a grievance (complaint) with BCBSAZ Health Choice. Or, you may be asked to assist or represent the member during the appeals process. Members determined to be Seriously Mentally Ill (SMI) are also afforded the right to an informal conference.
Information regarding the member appeal process are available under the Appeals and Grievance Section located in the Member tab of the BCBSAZ Health Choice website at: www.HealthChoiceAZ.com.

Providers may be requested to furnish information during the member grievance or appeal process. If information is required from your office, BCBSAZ Health Choice will conduct outreach efforts to request the required information.

A description of the processes for filing and handling of an appeal or a grievance may vary depending on the member's eligibility.

15.5.1 MEMBER APPEALS (TITLE XIX PROCESS)

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 www.HealthChoiceAZ.com, or through our Member Services Department.

15.5.2 HOW A MEMBER FILES AN APPPEAL (TITLE XIX PROCESS)

Members must file an appeal with BCBSAZ Health Choice either verbally by calling Member Services, or in writing, within 60 days of the date on the Notice of Action (NOA).
Although a request for an appeal must be initiated by the member, a member is allowed to ask a physician, or a representative such as a family member, to represent him/her during the appeal and/or hearing process. However, the member must give written permission for the doctor to represent them. BCBSAZ Health Choice will not conduct any retaliation activities against providers who represent or assist members during the hearing process.

If your physician is representing the member in the appeal, you must include a copy of the member's written permission. Submit the appeal and the representation authorization, directly to the Member Appeals Department at the address listed below:

Health Choice Arizona
Attention: Member Appeals
8220 N. 23rd Ave.
Phoenix, AZ 85021

Once the Appeal process has been initiated, BCBSAZ Health Choice will send the Member (and their representative, if applicable) an acknowledgment letter by postal mail. BCBSAZ Health Choice will respond to all Appeals within thirty (30) days from the date that BCBSAZ Health Choice received the Appeal. BCBSAZ Health Choice will mail a final written decision to the Member (and their representative, if applicable). If an extension is necessary, BCBSAZ Health Choice will notify the Member (and their representative, if applicable).

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.

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 72 hours 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 administrative hearing no later than thirty (30) days from the date of BCBSAZ Health Choice's decision, and how to do so.

In the event a request for an administrative hearing is filed with BCBSAZ Health Choice, BCBSAZ Health Choice shall ensure that the written request for a hearing, appeal case record, and all supporting documentation is received by AHCCCS OGA within five (5) days.

15.6 MEMBER GRIEVANCES (COMPLAINTS)

A member may file a Grievance (formerly a member Complaint) with BCBSAZ Health Choice regarding the dissatisfaction with any aspect of their care [other than the appeal of any Notice of Action letter (NOA)]. If a member wants to file a grievance, please direct him/her to BCBSAZ Health Choice Member Services at (800) 322-8670, or inform him/her that he/she can submit his/her grievance in writing to:

Health Choice Arizona
Attention: Member Grievances
8220 N. 23rd Ave.
Phoenix, AZ 85021

If the grievance is against a provider, BCBSAZ Health Choice will contact their office to obtain input on the grievance.