CHAPTER 11 INQUIRIES, GRIEVANCES, CLAIM DISPUTES, AND APPEALS

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EFFECTIVE DATE: March 29, 2013

REFERENCES: Division Operations Policy 414 and 6003-G, 6003-H

PURPOSE

This policy provides guidelines for provider Inquiries, Grievances, Claim Disputes, State Fair Hearings (regarding Notice of Decision), and Appeals. For Member Inquiries and Grievances, refer to Division Operations Policy 6003-G.

DEFINITIONS

1. "Action" means a denial or limited authorization of a new service, denial to increase an authorized service, reduction of an authorized service, suspension of an authorized service, or termination of an authorized service.

2. "Appeal" means a request for review of an Adverse Benefit Determination.

3. "Business Day" means 8:00 a.m. to 5:00 p.m., Monday through

Friday, excluding holidays listed in A.R.S. § 1-301.

4. "Claim Dispute" means a dispute, filed by a Provider or DDD service Provider, whichever is applicable, involving payment of a claim, denial of a claim, imposition of a sanction, or reinsurance.

5. "Complainant" means the person(s) expressing dissatisfaction or requesting to file a grievance.

6. "Expedited Appeal" means an Appeal conducted within 72 hours.

7. "Functional Area" means a business unit or department within the Division.

8. "Grievance" means a verbal or written expression of dissatisfaction with any matter, other than an Adverse Benefit Determination or provider Inquiries that are older than 30 days.

9. "Inquiry" means a question received by the Customer Service Center.

10. "Member" means a person receiving developmental disabilities services from the Division.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

POLICY

A. INQUIRIES

1. Providers shall contact the Division's Customer Service Center (CSC), to submit an Inquiry, by:
   a. Phone - 1-844-770-9500 option 1, or
   b. Email - DDDcustomerservice-providers@azdes.gov, or
   c. Mail - DES/DDD Customer Service Center
      1789 W. Jefferson St.
      Mail Drop 2HB3
      Phoenix, AZ 85007

B. GRIEVANCES

1. The Provider shall contact the Division's CSC to file a Grievance.

2. The Provider shall refer to Section A of this policy for contact information for the Division's CSC.

3. The Provider shall include the Grievance tracking number, received from the CSC, when sending any requested documentation needed to complete the Grievance investigation.

C. CLAIM DISPUTES

1. The Providers shall submit Claim Disputes in writing, by mail, email, or fax to:

   a. Mail: OFFICE OF ADMINISTRATIVE REVIEW (OAR)

      1789 W Jefferson St.

      Mail Drop 2HE5

      Phoenix Arizona 85007

      Email: dddofficeofcompliance@azdes.gov

   b. 602-771-8163

c. Fax: 602-277-0026

2. The Provider may file a claim dispute based on:

   a. A claim denial;

   b. Dissatisfaction with a claim payment; or

   c. Recoupment action by the Division.

3. The Provider may challenge a claim denial or adjudication by filing a formal Claim Dispute with the Divisions Office of Administrative Review (OAR).

4. The Provider shall file a Claim Dispute with OAR:

   a. No later than 12 months from the date of service;

   b. 12 months after the date of eligibility posting; or

   c. Within 60 calendar days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

5. When a Claim Dispute is filed with OAR, the Provider shall:

   a. Include the factual and legal basis for the relief requested;

b. Provide all supporting documentation; and

c. Ensure the Claim Dispute is complete, accurate, and submitted timely to prevent a denial.

6. The Provider shall contact OAR when the Provider needs an extension to submit supporting documentation when filing a Claim Dispute.

7. The Provider shall approve or deny the Division's request to extend the Notice of Decision beyond the 30 day deadline.

D. APPEALS

1. When the Division takes an Action, the Provider, with the Responsible Person's written consent, shall:
   a. Request an Appeal; and
   b. Advocate on behalf of the Responsible Person throughout the Appeal process.
2. The Provider shall not be prohibited by the Division from filing an Appeal or advocating on behalf of the Member when the Provider

has obtained written consent from the Responsible Person.

3. When the Provider submits an Appeal to the Division, the Provider shall submit the Appeal:

   a. Verbally or in writing to OAR; and

   b. Within 60 calendar days from the date of the Notice Adverse Benefit Determination.

4. The Provider, on behalf of the Responsible Person, may request an Expedited Appeal when the standard timeframes for issuing an authorization decision could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

E. STATE FAIR HEARINGS (REGARDING NOTICE OF DECISION)

1. The Provider, on behalf of the Responsible Person, shall submit a written request for a State Fair Hearing within 30 calendar days of receipt of the Notice of Decision.

2. When requesting a State Fair Hearing, the Provider shall provide:

a. Subject Line - Re: Request for State Fair Hearing;

b. DDD Claim Dispute Number;

c. Member Name and AHCCCS ID; and

d. The total dollar amount being disputed.

3. Providers shall submit requests for State Fair Hearing to OAR.

4. The Provider shall refer to Section A of this policy for contact information for the Division's CSC.

5. Providers shall contact the CSC with any questions.

6. The Provider shall refer to Section A of this policy for contact information for the Division's CSC.

SUPPLEMENTAL INFORMATION

The Provider shall not be prohibited by the Division from filing an Appeal or advocating on behalf of the Member when the Provider has obtained written consent from the Responsible Person.