CHAPTER 15:

Claim Disputes, Member Appeals and Member Grievances

Reviewed/Revised: 10/1/18, 12/15/19, 1/1/20, 06/18/21, 12/1/21, 9/1/22, 8/1/23

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 <u>Reconsideration</u>. 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:

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.

- **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

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 or (928) 774-7128 for RBHA service disputes.

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 dates tamp 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). Providers may choose to appear in person, or telephonically. To appear telephonically, a request must be submitted to OAH at least 14 days prior to the hearing date.
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.

Appeal of AHCCCS Director's decisions:

- For Title XIX and Title XXI covered services, an appellant aggrieved by the Director's decision may appeal the decision to AHCCCS by filing a written notice of appeal within 30 calendar days of receipt of the decision to:

  AHCCCS
  Office of Administrative Legal Services
  -801 E. Jefferson St., MD-6200
  Phoenix, AZ 85034

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.;

15.4.3 MEMBER NOTICE REQUIREMENTS (FOR MEMBERS WITH A SERIOUS MENTAL ILLNESS (SMI) /Non-Title XIX/XXI)

For actions (see definition) related to Title XIX/XXI covered services, see above Title XIX/XXI Notice and Appeal Requirements under section 15.4.1.

The following provisions apply to notice requirements for members determined to have a SMI and for members for which an SMI eligibility determination is being considered.
Members who are evaluated for an SMI eligibility determination must receive an **Appeal or SMI Grievance Form** at the time of determination.

Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness) must be provided to members determined to have a Serious Mental Illness or to members applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within 3 days of the eligibility determination;
- A decision is made regarding fees or waivers;
- The assessment report, service plan or individual treatment and discharge plan is developed, provided or reviewed;
- A decision is made to modify the services plan, or to reduce, suspend or terminate any service that is a covered service funded through Non-Title XIX funds[1]. In this case, notice must be provided at least 30 days prior to the effective date unless the member consents to the change in writing or a qualified clinician determines that the action is necessary to avoid a serious or immediate threat to the health or safety of the member receiving services or others;
- A decision is made that the member is no longer eligible for SMI services; and
- A Pre-Admission Screening and Resident Review (PASRR) determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Additional Notices

The following additional notices must be provided to members determined to have a Serious Mental Illness (SMI) or members applying for SMI services:

- Notice of Legal Rights for Members with Serious Mental Illness at the time of admission to a behavioral health provider agency for evaluation or treatment. The member receiving this notice must acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the member's comprehensive clinical record. All behavioral health providers must post **Notice of Legal Rights for Members with Serious Mental Illness (**in both English and Spanish, so that it is readily visible to behavioral health recipients and visitors);
- **Notice of Discrimination Prohibited**, posted in English and Spanish so that it is readily visible to members visiting the agency, and a copy provided at the time of discharge from the behavioral health provider agency.

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.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS OALS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

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

15.5.3 APPEAL REQUIREMENTS (PROCESS AFFORDED TO SMI MEMBERS ONLY)

Title XIX/XXI eligible members applying for or who have been determined to have a SMI and who are appealing an action affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI appeal process (see **Title XIX/XXI Notice and Appeal Requirements, above under 15.4.1**) or the appeal process for members determined to have a SMI described in **SMI and Non-SMI/Non-Title XIX/XXI, above under 15.4.2.**

Types of Appeal

There are two appeal processes applicable to this section:

- Appeals of members applying for an eligibility determination or who have been determined to have a SMI; and
- Appeals for other covered service related issues.

Filing Members and Entities

The following members and entities may file an appeal:

- An adult applying for or receiving behavioral health services, their legal guardian, guardian ad litem, designated representative or attorney, or if Special Assistance, the member meeting Special Assistance needs;
- A state or governmental agency that provides behavioral health services through an Interagency Service Agreement/Intergovernmental Agreement (ISA/IGA) with ADHS, but which does not have legal custody or control of the member, to the extent specified in the ISA/IGA between the agency and the ADHS; and
- A provider, acting on the behavioral health recipient's behalf and with the written authorization of the member.

Timeframes for Appeals

Appeals must be filed orally or in writing with Health Choice within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

Where to Appeal

- Oral Appeal: Call (928) 774-7128 or (877) 923-1400
- Fax Appeal: Fax to (855) 408-3400
- Written appeal: BCBSAZ Health Choice Attn: Appeals 1300 South Yale Street, Flagstaff AZ, 86001

15.5.4 APPEAL PROCESS FOR MEMBERS WITH SERIOUS MENTAL ILLNESS (SMI)

An appeal may be filed concerning one or more of the following:

- Decisions regarding the member's SMI eligibility determination;
- Sufficiency or appropriateness of the assessment;
- Long-term view, service goals, objectives or timelines stated in the Individual Service Plan (ISP) or Inpatient Treatment and Discharge Plan (ITDP);
- Recommended services identified in the assessment report, ISP or ITDP;
- Actual services to be provided, as described in the ISP, plan for interim services or ITDP;
- Access to or prompt provision of services;
- Findings of the clinical team with regard to the member's competency, capacity to make decisions, need for guardianship or other protective services, or need for Special Assistance;
- Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an ISP, ITDP or portion of an ISP or ITDP;
- Application of the procedures and timeframes for developing the ISP or ITDP;
- Implementation of the ISP or ITDP;
- Decision to provide service planning, including the provision of assessment or case management services to a member who is refusing such services, or a decision not to provide such services to the member;
- Decisions regarding a member's fee assessment or the denial of a request for a waiver of fees;
- Denial of payment of a claim;
- Failure of Health Choice or AHCCCS to act within the timeframes regarding an appeal; or
- A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Standard Appeal Process

Within 5 working days of receipt of an appeal, BCBSAZ Health Choice must inform the appellant in writing that the appeal has been received and of the procedures that will be followed during the appeal.

In the event BCBSAZ Health Choice refuses to accept a late appeal or determines that the issue may not be appealed BCBSAZ Health Choice must inform the appellant in writing that they may,

within 10 days of their receipt of BCBSAZ Health Choice's decision, request an Administrative Review of the decision with the AHCCCS OGA.

If a timely request for Administrative Review is filed with AHCCCS of BCBSAZ Health Choice's decision, AHCCCS shall issue a final decision within 15 days of the request.

Informal Conference with BCBSAZ Health Choice

Within 7 days of receipt of an appeal, BCBSAZ Health Choice shall hold an informal conference with the member, guardian, any designated representative, case manager or other representative of the service provider, if appropriate.

BCBSAZ Health Choice must schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant's right to be represented by a designated representative of the appellant's choice.

The informal conference shall be chaired by a representative of BCBSAZ Health Choice with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute.

The BCBSAZ Health Choice representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.

If the issues in dispute are resolved to the satisfaction of the member or guardian, if applicable, BCBSAZ Health Choice shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute do not relate to the member's eligibility for behavioral health services, the member or guardian shall be informed that the matter will be forwarded for further appeal to AHCCCS for informal conference, and of the procedure for requesting a waiver of the AHCCCS informal conference.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute relate to the member's eligibility for SMI services or the member or guardian has requested a waiver of the AHCCCS informal conference in writing, BCBSAZ Health Choice shall:

- Provide written notice to the member or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the member or guardian is requesting BCBSAZ Health Choice to request an administrative hearing on behalf of the member or

guardian and, if so, file the request with AHCCCS within three (3) days of the informal conference.

- For a member who is in need of special assistance, send a copy of the appeal, results of the informal conference and notice of administrative hearing to the Office of Human Rights (OHR).
- In the event the member appealing fails to attend the informal conference and fails to notify BCBSAZ Health Choice of their inability to attend prior to the scheduled conference, BCBSAZ Health Choice shall reschedule the conference. If the member appealing fails to attend the rescheduled conference and fails to notify BCBSAZ Health Choice of their inability to attend prior to the rescheduled conference, BCBSAZ Health Choice will close the appeal docket and send written notice of the closure to the member appealing.
    - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, BCBSAZ Health Choice can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with BCBSAZ Health Choice, BCBSAZ Health Choice must forward the appeal case record to the AHCCCS OGA within three days from the conclusion of the informal conference.

AHCCCS Informal Conference

Unless the member or guardian waives an informal conference with AHCCCS or the issue on appeal relates to eligibility for SMI services, AHCCCS shall hold a second informal conference within 15 days of the notification from BCBSAZ Health Choice that the appeal was unresolved.

- At least five (5) days prior to the date of the second informal conference, AHCCCS shall notify the participants in writing of the date, time and location of the conference.
- The informal conference shall be chaired by a representative of AHCCCS with authority to resolve the issues under appeal who shall seek to mediate and resolve the issues in dispute.
- The AHCCCS representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented, and identify any unresolved issues for further appeal.
- If the issues in dispute are resolved to the satisfaction of the member or guardian, AHCCCS shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.
    - For a member in need of Special Assistance, AHCCCS shall send a copy of the informal conference report to the OHR.
- If the issues in dispute are not resolved to the satisfaction of the member or guardian, AHCCCS shall:
    - Provide written notice to the member or guardian of the process to request an administrative hearing.
    - Determine at the informal conference whether the member or guardian is requesting AHCCCS to request an administrative hearing on behalf of the member or guardian and, if so, file the request within three (3) days of the informal

conference.
- For a member who is in need of Special Assistance, send a copy of the notice to the OHR.
- In the event the member appealing fails to attend the informal conference and fails to notify AHCCCS of their inability to attend prior to the scheduled conference, AHCCCS may issue a written notice, within three (3) working days of the scheduled conference, which contains a description of the decision on the issue under appeal and which advises the appellant of their right to request an Administrative Hearing.
- In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, AHCCCS can re-open the appeal and proceed with the informal conference.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS OALS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with BCBSAZ Health Choice, BCBSAZ Health Choice shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within three (3) days from such date. Administrative hearings shall be conducted and decided pursuant to A.R.S. § 41-1092 et seq.

Expedited appeals

A member, or a provider on the member's behalf, may request an expedited appeal for the denial or termination of crisis or emergency services, the denial of admission to or the termination of a continuation of inpatient services, if inpatient services are a covered benefit, or for good cause.

Within one (1) day of receipt of a request for an expedited appeal, BCBSAZ Health Choice must inform the appellant in writing that the appeal has been received and of the time, date and location of the informal conference; or

Issue a written decision stating that the appeal does not meet criteria as an expedited appeal and that the appellant may request an Administrative Review from AHCCCS of this decision within three (3) days of the decision. The appeal shall then proceed according to the standard process described in this chapter.

Expedited Informal Conference

Within two (2) days of receipt of a written request for an expedited appeal, BCBSAZ Health Choice shall hold an informal conference to mediate and resolve the issues in dispute.

AHCCCS Expedited Informal Conference

Within two (2) days of notification from BCBSAZ Health Choice, AHCCCS shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference at this level, in which case the appeal shall be forwarded within one (1) day to the AHCCCS OALS to schedule an administrative hearing.

Within one day of the informal conference with AHCCCS, if the conference failed to resolve the appeal, the appeal shall be forwarded to the AHCCCS OALS to schedule an administrative hearing.

Continuation of Services during Appeal Process

For members determined to have a SMI, the member's behavioral health services will continue while an appeal of a modification to or termination of a covered behavioral health service is pending unless:

- A qualified clinician determines the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the member or another individual; or
- The member or, if applicable, the member's guardian, agrees in writing to the modification or termination.

15.5.5 APPEALS FOR NON-TITLE XIX/XXI/ NON SMI POPULATION

Based on available funding, a member who is Non-Title XXI/XXI and Non-SMI may file an appeal of a decision that is related to a determination of need for a covered service (e.g., modification to previously authorized services for a non-Title XIX/XXI eligible member). In these circumstances, there is no continuation of services available during the appeal process.

BCBSAZ Health Choice in processing the appeal must:

- Inform the appellant in writing within five (5) working days of receipt that the appeal has been received and of the procedures that will be followed during the appeal;
- Provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in person and in writing; and
- Provide a written decision no later than thirty (30) days from the day the appeal is received. The decision shall include a summary of the issues involved, the outcome of the appeal, and the basis of the decision. 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.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS OALS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant

and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

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

BEHAVIORAL HEALTH PROVIDER RESPONSIBILITIES

While providers are not directly responsible for the resolution of appeals, they are required to actively participate in the process as follows:

- Provide information deemed to be necessary by BCBSAZ Health Choice, AHCCCS or the Office of Administrative Hearings (e.g., documents and other evidence); and
- Cooperate and participate as necessary throughout the appeal process.

Providers must be available to assist a member in the filing of an appeal. For members determined to have a SMI, the Office of Human Rights may be available to assist the member in filing as well as resolving the appeal.

Providers must not retaliate against any member who files an appeal or interfere with a member's right to file an appeal. Additionally, no punitive action may be taken against a behavioral health provider who supports a member's appeal.

15.6 MEMBER GRIEVANCES (COMPLAINTS) NON-SMI RECIPIENTS

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.

15.7 CONDUCT OF INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS (SMI)

GENERAL REQUIREMENTS

Per **AHCCCS 446- Grievances and Investigations concerning Persons with Serious Mental Illness**, members requesting or receiving services shall be notified of their right to file grievances or request investigations. BCBSAZ Health Choice shall respond to grievances and requests for investigations in accordance with this policy and the requirements and timelines contained in **9 A.A.C. 21, Article 4**.

Computation of Time - In computing any period of time prescribed or allowed by this policy, the period begins the day after the act; event or decision occurs 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. If the period of time is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays and legal holidays must not be included in the computation.

AHCCCS and BCBSAZ Health Choice shall use the unique AHCCCS Docket Number auto-generated by the Office of Grievance and Appeals (OGA) database for each appeal filed. The file and all correspondence generated shall reference the AHCCCS Docket Number.

AGENCY RESPONSIBLE FOR RESOLVING GRIEVANCES AND REQUESTS FOR INVESTIGATION

Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by BCBSAZ Health Choice or one of its subcontracted providers, and which does not involve a client death or an allegation of physical or sexual abuse, shall be filed with and investigated by BCBSAZ Health Choice.

Grievances or requests for investigation involving physical or sexual abuse or death that occurred in either an agency which is operated by BCBSAZ Health Choice or one of its subcontracted providers or as a result of an action of a person employed by BCBSAZ Health Choice or one of its subcontracted providers are investigated by AHCCCS.

Grievances involving a rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists and which occurred in an agency that is not BCBSAZ Health Choice or their subcontracted providers, shall be addressed to the appropriate regulatory division or agency.

The AHCCCS Deputy Director, or designee, the BCBSAZ Health Choice Chief Executive Officer (CEO), before whom a grievance or request for investigation is pending, shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, complainant or witness.

GRIEVANCE/REQUEST FOR INVESTIGATION PROCESS

Timeliness and Method for Filing Grievances

Grievances or a request for investigation must be submitted to AHCCCS, or BCBSAZ Health Choice, orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by the AHCCCS' Deputy Director, or designee, or the BCBSAZ Health Choice Medical Director, before whom the grievance or request for investigation is pending.

All SMI grievances or requests for investigation must be submitted orally or in writing to:

BCBSAZ Health Choice
Attn: SMI Grievances and Appeals
1300 South Yale Street
Flagstaff, AZ 86001
Fax Number: (855) 408-3400
Phone: (928) 774-7128 or (877) 923-1400

SMI Grievances/requests for investigation related to abuse or death may also be filed directly with AHCCCS at 801 East Jefferson, MD-6200, Phoenix, AZ 85034, (602) 364-4575.

Within five (5) days of receipt of a grievance or request for investigation, AHCCCS, or BCBSAZ Health Choice, must inform the person filing the grievance or request for investigation, in writing, that the grievance or request has been received.

Any employee or contracted staff of AHCCCS, BCBSAZ Health Choice or its subcontracted provider, shall, upon request, assist a person receiving services, or their legal guardian, in making an oral or written grievance or request for investigation or direct the person to an available supervisory or managerial staff who shall assist the person to file a grievance or request for investigation.

All oral grievances and requests for investigation must be accurately reduced to writing by AHCCCS, BCBSAZ Health Choice or its subcontracted provider that receives the grievance or request, on the **AHCCCS Appeal or SMI Grievance Form.**

Preliminary Disposition

Summary Disposition – AHCCCS, or BCBSAZ Health Choice Director or designee, may summarily dispose of a grievance or request for investigation, which shall not include any notice or right for further review or hearing, when:

- The alleged violation occurred more than one year prior to the date of request; or
- The grievance request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in **9 A.A.C. 21, Articles 3 and 4**.

Disposition without Investigation

Within seven (7) days of receiving a grievance or request for investigation, the AHCCCS, or BCBSAZ Health Choice Director or designee, may resolve the matter without conducting a full investigation when:

- The matter involves no material dispute as to the facts alleged in the grievance or request for investigation;
- The allegation is frivolous, meaning that it:
    - Involves conduct that is not within the scope of Title 9, Chapter 21;
    - Is impossible on its face; or
    - Is substantially similar to conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated.
- Is resolved fairly and efficiently within seven days without a formal investigation.

Within seven (7) days of the grievance or request for investigation, the AHCCCS, or BCBSAZ Health Choice's Director or designee, shall prepare a written dated decision which shall explain the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution. The written decision shall contain a notice of appeal rights, and information to request assistance from the Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision shall be sent to the person filing the grievance or request for investigation and to the OHR for persons who need special assistance.

Conducting Investigation of Grievances

Within seven (7) days of receipt of a grievance or request for investigation, AHCCCS, or BCBSAZ Health Choice, must inform the person filing the grievance or request for investigation, in writing, of the appointment of an investigator and of the procedure by which the investigation will be conducted. AHCCCS, and BCBSAZ Health Choice shall conduct the investigation pursuant to **A.A.C. R9-21-406**.

If an extension of any time frame related to the grievance process in **A.A.C. R9-21, Article 4** is needed; it must be requested and approved in compliance with **A.A.C. R9-21-410(B)**. Specifically:

- BCBSAZ Health Choice investigator or any other official responsible for responding to grievances must address their extension request to BCBSAZ Health Choice Director or designee.
- The AHCCCS investigator or any other AHCCCS official responsible for responding to grievances must address their extension request to the AHCCCS Deputy Director or designee; and
- A BCBSAZ Health Choice request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by AHCCCS decisions relating to a grievance shall be addressed to the AHCCCS Deputy Director or designee.

Grievance Investigations – Allegations of Rights Violations

The investigator shall:

- Interview the person who filed the grievance and the person receiving services who is identified as the subject of the violation (if different) prior to interviewing the person alleged to be the perpetrator of the rights violation.
- If the person who is the subject of the investigation needs special assistance, the investigator shall contact the person's advocate; or if no advocate is assigned, the person shall contact OHR, and request that an advocate be present to assist the person during the interview and any other part of the investigation process.
- Request assistance from the OHR if the person identified as the subject needs assistance to participate in the interview and any other part of the investigation process.
- Within thirty (30) days from the date of appointment, the investigator shall prepare a written report that contains at a minimum:
    - A summary for each individual interviewed of information provided by the individual during the interview conducted;
    - A summary of relevant information found in documents reviewed;
    - A summary of any other activities conducted as a part of the investigation;
    - A description of any issues identified during the course of the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation;
    - A conclusion, based on the facts obtained in the investigation, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence. The conclusion must describe those findings and/or factors that led to this determination; and
    - Recommended actions or a recommendation for required corrective action, if indicated.

Decisions

Within five (5) days of receipt of the investigator's report, AHCCCS's Deputy Director, or designee or BCBSAZ Health Choice Director or designee, shall review the investigation case record, and the report, and issue a written, dated decision which shall either:

- Accept the report and state a summary of findings and conclusions and any action or corrective action required, and send copies of the decision, subject to confidentiality requirements (provided for in Chapter 18 – Behavioral Health Services) to the investigator, BCBSAZ Health Choice Director, the person who filed the grievance, the person receiving services identified as the subject of the violation or abuse (if different), the AHCCCS Office of Human Rights for persons deemed in need of Special Assistance. The decision sent to the grievant and the person who is the subject of the grievance (if different) shall include a notice of the right to request an administrative appeal of the decision within 30 days from the date of receipt of the decision. The decision must be sent to the grievant by certified mail or by hand-delivery.
- Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report to

AHCCCS's Deputy Director, or designee, BCBSAZ Health Choice Director, within ten 10 days.

Actions

AHCCCS's Deputy Director, or designee, or the BCBSAZ Health Choice Director may identify actions to be taken, as indicated above, which may include:

- Identifying training or supervision for or disciplinary action against an individual found to be responsible for a rights violation or condition requiring investigation identified during the course of investigation of a grievance or request for investigation;
- Developing or modifying a mental health agency's practices or protocols;
- Notifying the regulatory entity that licensed or certified an individual according to **A.R.S. Title 32, Chapter 33** of the findings from the investigation; or
- Imposing sanctions, which may include monetary penalties, according to the terms of a contract, if applicable.

Disagreement with Decision

A grievant or the client who is the subject of the grievance, who disagrees with the final decision of BCBSAZ Health Choice, may file a request for an administrative appeal within 30 days from the date of their receipt of BCBSAZ Health Choice decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of BCBSAZ Health Choice decision.

Administrative Appeal

In the event an administrative appeal is filed, BCBSAZ Health Choice, shall forward the full investigation case record, which includes all elements in **A.A.C. R9-21-409(D)(1)**, to AHCCCS, or designee through the AHCCCS OGA. The failure of BCBSAZ Health Choice to forward a full investigation case record that supports BCBSAZ Health Choice decision may result in a summary determination in favor of the person filing the administrative appeal. BCBSAZ Health Choice shall prepare and send with the investigation case record, a memo in which BCBSAZ Health Choice states:

- Any objections BCBSAZ Health Choice has to the timeliness of the administrative appeal,
- BCBSAZ Health Choice's response to any information provided in the administrative appeal that was not addressed in the investigation report, and
- BCBSAZ Health Choice understanding of the basis for the administrative appeal.

Within 15 days of the filing of the administrative appeal, AHCCCS will review the appeal and the investigation case record and may discuss the matter with any of the persons involved or convene an informal conference, and prepare a written, dated decision which shall either:

- Accept the investigator's report with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons. The decision, along with a notice of the right to request an administrative hearing within thirty (30) days from the date of receipt of the decision, shall be sent to the appealing party, with copies of the decision

provided to the BCBSAZ Health Choice Director, as indicated; the OHR and the applicable human rights committee; or

- Reject the investigator's report for insufficiency of facts and remand the matter with instructions to BCBSAZ Health Choice for further investigation and decision, BCBSAZ Health Choice shall conduct further investigation and complete a revised report and decision to AHCCCS within ten (10) days. Upon receipt of the report and decision, AHCCCS shall render a final decision consistent with the procedures described above; or;

- Reject BCBSAZ Health Choice's decision and remand the matter with instructions to BCBSAZ Health Choice to conduct an investigation, or to conduct further investigation, issue an initial, or revised, decision, and include a notice of the right of the grievant or client who is the subject of the grievance to request an administrative appeal to AHCCCS of the decision within thirty (30) days from the date of receipt of the decision, consistent with the requirements in **A.A.C. R9-21-406**, et. seq.

A grievant or person who is the subject of the grievance who is dissatisfied with the decision of AHCCCS may request an administrative hearing before an administrative law judge within 30 days of the date of the decision. Upon receipt of a request for a hearing, the hearing shall be scheduled and conducted according to the requirements in A.R.S. §41-1092 et seq.

After the expiration of the time frames for administrative appeal and administrative hearing as described above, or after the exhaustion of all appeals regarding outcome of the investigation, BCBSAZ Health Choice, or designee of the AHCCCS, shall take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report shall be sent to the AHCCCS OHR for persons in need of Special Assistance.

Grievance Investigation Records and Tracking System

AHCCCS and BCBSAZ Health Choice will maintain records in the following manner:

- All documentation received and mailed related to the grievance and investigation process will be date stamped on the day received.
- AHCCCS and BCBSAZ Health Choice will maintain a grievance investigation case record for each case. The record shall include:
  - The assigned docket number ;
  - The original grievance/investigation request letter and the AHCCCS Appeal or SMI Grievance Form;
  - Copies of all information generated or obtained during the investigation;
  - The investigator's report which will include a description of the grievance issue, documentation of the investigative process, names of all persons interviewed, written documentation of the interviews, summary of all documents reviewed, the investigator's findings, conclusions and recommendations;
  - A copy of the acknowledgment letter, final decision letter and any information/documentation generated by an appeal of the grievance decision.

- AHCCCS, and BCBSAZ Health Choice will maintain all grievance and investigation files in a secure designated area and retain for at least five (5) years.
- The Public Log – AHCCCS OGA, BCBSAZ Health Choice will maintain a public log of all grievances or requests for investigation in AHCCCS's OGA Database which shall be considered the public record. Entry must be made within three (3) working days of each reportable event. The Public Log will contain the following information:
  - A docket number;
  - A description of the grievance or request for investigation issue;
  - The date of the filing of grievance;
  - The date of the initial decision or appointment of the investigator;
  - The date of the filing of the investigator's final report;
  - The dates of all subsequent decisions, appeals or other relevant events;
  - A description of the final decision and any actions taken by the AHCCCS Deputy Director, or designee, BCBSAZ Health Choice Director.

OTHER MATTERS RELATED TO GRIEVANCE PROCESS

Pursuant to the applicable statutes, BCBSAZ Health Choice shall maintain confidentiality and privacy of grievance matters and records at all times.