State of Arizona

Guidelines and Procedures for Members Who Want to Appeal or Grieve an Adverse Benefit Determination

CAREFULLY READ THE INFORMATION IN THIS PACKET. KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL ADVERSE DETERMINATIONS MADE ABOUT YOUR HEALTHCARE.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

ARIZONA DEPARTMENT OF ADMINISTRATION
BENEFITS SERVICES DIVISION

WHAT IS AN ADVERSE BENEFIT DETERMINATION?

An adverse benefit determination occurs when AZ Blue[1], as administrator of your health benefit plan ("plan"), makes any of the following decisions:

- Denies your request for prior authorization of a service you haven't yet received;
- Denies, reduces, or terminates your plan benefits;
- Fails to provide or pay for a benefit you think is covered under your plan;
- Finds you ineligible for a benefit under your plan;
- Finds you responsible for payment of cost share (copay, deductible, coinsurance, access fee, balance bill) for a plan benefit;
- Finds that a service is not medically necessary;
- Finds that a service is not covered because it is experimental or investigational;
- Determines that you are not eligible for coverage under the benefit plan; or

AZ Blue may contract with independent third parties ("vendors") to administer some of your benefits. A vendor may also issue an adverse benefit determination. Your benefit plan booklet will provide contact information for any vendors that administer specific benefits under your plan.

How will I know when you make one of these decisions?

We send you written notice in the form of an "Explanation of Benefits" (EOB) document, a monthly member health statement, or a letter. All of these documents include information about your right to appeal or grieve the decision.

I disagree with how you processed my claim. What do I need to do?

Call us at the numbers listed below to explain your situation. Keep in mind that we have to follow the terms of your plan. We can't change the scope of your coverage or rewrite your cost share obligations. But, if we've made a mistake in how we administered your benefits, we want to fix it.

How do I contact you?

Call AZ Blue Customer Service Monday through Friday, 7:00 a.m. to 6:00 p.m. MST (except holidays).
You can reach us at **1-866-287-1980.**

If the Chiropractic Benefits Administrator issued your decision call **1-800-678-9133.**

[1]AZ Blue also contracts with an independent third party to administer benefits for services by a chiropractor (the "CBA). The CBA may issue some of these decisions and may perform the review at one or more levels. References in this brochure to AZ Blue will include the CBA when they are administering benefits for AZ Blue.

What if I still disagree with your decision after speaking with a representative?

You have the right to file an appeal or grievance, free of charge. Information on where to file an appeal or grievance is included on your Explanation of Benefits statement (EOB), your monthly health statement, or a denial letter. Additional contact information is listed in your benefit plan booklet. These resources identify if AZ Blue or a vendor made the prior authorization decision or processed your claim. Whoever makes the decision or processes the claim usually handles your appeal or grievance as well.

The process available to you, and the steps in that process, will vary, based on:

- Whether you are challenging a denial of an urgently needed service that you haven't yet received and/or
- The type of decision you disagree with:
  - If we denied a claim or a prior authorization for a service, you have 2 years from the date of denial to request an appeal.
  - If you disagree with how we paid the claim (i.e., copay, deductible, coinsurance, level of benefits, etc.), you have 2 years from the date of the notice to file a grievance. (When your dispute is about how we applied cost share, we call it a "grievance".
  - Whether you or your provider bears financial responsibility for the decision (AZ Blue contracted providers are sometimes required to write off charges for certain services excluded from coverage under your benefit plan.)

You denied prior authorization for a service that I need right away. What do I do?

We have an expedited appeal process for members who urgently need a service that has not yet been provided. A service is urgently needed when the time period for a standard appeal could seriously jeopardize a member's life, health, or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed without the requested service. If you have not yet received a service, and your treating provider certifies that your condition qualifies as urgent, AZ Blue treats the appeal as urgent.

Is there anyone who can help me with my appeal?

AZ Blue customer service representatives can answer questions about the appeal process and help you with filing an appeal. The AZ Blue customer service number is 1-866-287-1980 (toll free). Keep in mind that Arizona state insurance laws generally do not apply to self-funded group health plans. At the end of this brochure are forms that you may use for your appeal. You are not required to use these forms.

WHAT ARE THE PROCESSES FOR APPEALS AND GRIEVANCES?

The following charts show the processes for both expedited and standard appeals and for grievances.

Internal review by AZ Blue (or AZ Blue Contracted Vendor)		
Level 1 – Initial	**Expedited Appeals**	**Standard Appeals**
If you disagree with an AZ Blue decision, how long do you have to file an appeal?	2 years, but if you wait a long time after we deny prior authorization for a requested service, it usually means that the appeal does not require expediting, and can follow the standard process.	2 years from the date of the decision with which you disagree.
What do you need to send for an appeal?	You and your provider must send us any information that you want us to consider. Make sure to include at least the following information in your appeal request: • The decision or action you disagree with, • Why you think our original decision is wrong, • What you are asking AZ Blue to do differently, and • Any medical records that support your request No special form is required. At the end of this brochure, is an optional appeal form that you can use.	
	Your provider needs to certify that the appeal involves an urgent medical situation. At the end of this brochure is a certification form that your provider can use, but is not required to use. Your provider's signature attesting to the urgency of your situation is required.	
Where do you send your appeal?	You or your provider can fax, call or write to:	
For all appeals, except those related to services by a chiropractor, send to:	AZ Blue Medical Appeals & Grievances Specialist AZ Blue Mail stop A116 P.O. Box 13466 Phoenix, AZ 85002-3466 AZ Blue State of AZ Care Guide Phone 1-866-287-1980 Fax 602-544-5601	
For services by a chiropractor	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509001 San Diego, CA 92150-9001 Telephone 1-800-678-9133 Fax 619-209-6237	
Who will review your case?	Someone who was not involved in making the decision you are appealing, and who is not compensated, rewarded or promoted for upholding the original decision. For issues involving medical judgment, the review will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved.	
How long does AZ Blue have to notify you of its decision?	AZ Blue notifies you by phone within 72 hours from the time of your request and by mail within three (3 calendar days)	AZ Blue acknowledges receipt of your appeal within five (5) business days. For decisions related to prior authorization denials, we will send you a written decision within fifteen (15) days of receiving your request. For decisions related to claim denials for services already provided, we will send you a written decision within thirty (30) days of receiving your request.
What can you do if you still disagree with the decision?	You can request a second level of appeal.	

Internal Level 2		
Level 2 – Initial	**Expedited Appeals**	**Standard Appeals**
Amount of time you have to appeal to this Internal Level 2.	Sixty (60) days but if you wait a long time after the initial denial, it usually means that the appeal does not require expediting, and can follow the standard process.	Send a written request within sixty (60) days after receiving the Level 1 denial.
Send all appeals, except those related to services by a chiropractor to:	Medical Appeals & Grievances Coordinator AZ Blue Mail stop A116 P.O. Box 13466 Phoenix, AZ 85002-3466 AZ Blue State of AZ Care Guide Phone 1-866-287-1980 Fax 602-544-5601	
Send appeals for services by a chiropractor to:	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509001 San Diego, CA 92150-9001 Telephone 1-800-678-9133 Fax 619-209-6237	
How long does AZ Blue have to notify you of its decision?	AZ Blue notifies you by phone within 72 hours from the time of your request and by mail within three (3 calendar days)	AZ Blue issues decisions related to prior authorization denials within fifteen (15) days of receiving your request, and decisions related to claim denials for services already provided within thirty (30) days of receiving your request.
What can you do if you still disagree with the decision?	You can request external independent review. External independent review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.	

External Independent Review Process		
Appeals Submitted to IRO (Independent Review Organization)	**Expedited Appeals**	**Standard Appeals**
Amount of time you have to appeal this to External Independent Review	Four (4) months but if you wait a long time after the second denial, it usually means that the appeal does not require expediting, and can follow the standard process.	Send a written request within four (4) months after receiving the Level 2 denial.
Submission of additional information	The IRO will notify you that it has accepted your case. You have up to 10 business days to provide the IRO with more information that you want the IRO to consider.	
Other time periods	If you provide the IRO with new information, the IRO has 1 business day to send it to AZ Blue. Based on the new information, AZ Blue may decide to change its internal decision, and would notify you and the IRO of this change.	
Time period for IRO to issue a decision.	The IRO must issue a decision as quickly as possible in light of the medical circumstances, but no later than 72 hours after receiving the request for external review. If the IRO's decision is not issued in writing, the IRO has another 48 hours to provide written confirmation of the decision.	The IRO must issue a decision within 45 days after receiving the request for external review.
What happens after the IRO's decision?	If the IRO upholds AZ Blue's decision, you may have other legal recourse to challenge AZ Blue's decision in court. If the IRO reverses or modifies the decision in your favor, AZ Blue must comply with the IRO's decision.	

MEMBER GRIEVANCE

Process to Dispute Decisions about Member Cost Share
(For denial of a prior authorization or claim see Appeals page 3)

Step	Response Period
Level 1 – Initial Review	
Time period you have to file your grievance	2 years from the date of the decision or action that you are grieving. AZ Blue has discretion to extend this time limit for good cause (i.e. death in your immediate family or serious illness of you or someone in your immediate family.)
Time period for AZ Blue to notify you of its decision	Pre-service issues: Within fifteen (15) days from the date AZ Blue receives your grievance request. Post-service claims: Within sixty (60) days from the date AZ Blue receives your grievance request.
Where do you send your grievance?	Your provider can fax, call or write to AZ Blue at:
For all grievances, except services by a chiropractor, send to:	AZ Blue Medical Appeals & Grievances Department AZ Blue Mail stop A116 P.O. Box 13466 Phoenix, AZ 85002-3466 AZ Blue State of Arizona Care Guide Phone 1-866-287-1980 Fax 602-544-5601
For services by a chiropractor send to:	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509001 San Diego, CA 92150-9001 Telephone 1-800-678-9133 Fax 619-209-6237
Level 2	
Amount of time you have to submit your Level 2 grievance if you are dissatisfied with the initial decision	Send a written request within 60 days after receiving the Level 1 decision.
Time period for AZ Blue to notify you of its decision.	For most grievances, within 60 days from the date AZ Blue receives your request to grieve to the voluntary level. If the grievance is pre-service, within 15 days from the date of your request. AZ Blue may extend the time limit if necessary and in accordance with applicable law. AZ Blue will notify you in writing of any extension and the reason for it.
What can you do if you still disagree with AZ Blue's decision?	For issues about member cost share, that do not involve questions of medical judgment, no further review is available. You may have other legal recourse to challenge AZ Blue's decision in court.

Can I have someone else file the appeal or grievance for me?

You can authorize someone else to file an appeal or grievance on your behalf. The individual you designate will be your "authorized representative." Once you designate someone as your authorized representative, that person has the right to make decisions about your case (for example, whether to seek review at a higher level, if available.) Also, AZ Blue will send information about the progress of your case to the representative, with a copy to you.

For most plans, the following individuals are always authorized to appeal or grieve a decision and do not need any special authorization form:

- Your treating provider acting on your behalf; and
- A parent on behalf of a minor.

Your plan does require a special authorization for these individuals, we will let you know and make sure you have time to get the authorization. Also, the following individuals may appeal or grieve a decision for you, if you send AZ Blue the required proof of authority:

Designated Representative	Required Proof of Authority
Member's legal guardian	Official copy of the court order appointing the guardian.
Your agent	Power of attorney that complies with A.R.S. § 14-5501 (or equivalent statute from other state) authorizing the agent to appeal or grieve a healthcare decision; or Health care power of attorney that complies with A.R.S. § 36-3221 (or equivalent) and authorizes the agent to make health care treatment decisions for you.
Your surrogate	Someone who qualifies as a surrogate as defined by A.R.S. § 36-3231 (or equivalent statute from another state) and includes a written confirmation from a treating provider that the member is unable to make or communicate health care treatment decisions.
Executor or personal representative.	Official copies of the death certificate and court order appointing the executor or personal representative.
Court appointed representative (adult authorized by any other type of court order to make health care decisions for a member).	Official copy of the court order.

You may use a Confidential Information Release Form (CIRF) to designate an authorized representative to request an appeal on your behalf. If AZ Blue receives an appeal or grievance request from a third party who claims to be your authorized representative, including those situations shown above, AZ Blue may require you to confirm directly to us in writing the scope of any authority the third party may have. In that case, we will not recognize the third party's authority until we receive your confirmation.

How can I get medical records to send them to you?

Under Arizona law (A.R.S. §12-2293), you can ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or your authorized representative with a copy of your records. If you have to obtain medical records from your provider, your provider has the right to charge for copies of records, so you may have to pay for those copies.

If you have a designated health care decision-maker, that person must send a written request for access to copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker, unless you limit access to your medical records only to yourself or your health care decision-maker.

If you reside outside the state of Arizona, the laws that govern medical records and providers in your state may vary.

I am worried about sharing my medical information with so many people. Will my records be kept confidential?

If you participate in the appeal or grievance process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to others.

If I still disagree with the final decision, is there anything else I can do?

There is no further review available under the appeals or grievance process. However, you may have other remedies available under State or Federal law, such as rights to challenge the decision in court. You may be able to obtain information about what is available from your group benefits administrator.

Can I file a complaint with the Arizona Department of Insurance and Financial Institution (AZ DIFI)?

Your employer has a "self-funded" plan. The Arizona Department of Insurance and Financial Institutions does not have regulatory authority over your plan or your appeal or complaint about the plan.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Appeal/Grievance Request Form for State of Arizona Members

You may use this form to tell AZ Blue you want to appeal or grieve a decision.

BlueCross BlueShield Arizona

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Member Name _____

Member ID # _____ Group # _____

Name of representative pursuing appeal, if different than above _____

Phone # _____

Mailing Address _____

City _____ State _____ ZIP Code _____

Type of Appeal/Grievance ☐ Denied Claim ☐ Denied Service Not Yet Receive ☐ Cost Share Dispute

Claim # (if applicable) _____ Date of Service _____ / _____ / _____

If you are appealing AZ Blue's decision to deny a service you have not yet received, could a 15 to 30 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider can send us the attached certification and documentation supporting the need for an expedited appeal. What action or decision are you disputing?

_____

Explain why you believe the decision or action was wrong and what you want AZ Blue to do differently:

_____

_____

_____

(Attach additional sheets of paper, if needed)

If you have questions about the appeals or grievance process or need help to prepare your request, you may call AZ Blue at: **1-866-287-1980.**

Make sure that everything that shows why you believe AZ Blue should process your claim differently or authorize a service, including: ☐ Medical Records ☐ Supporting Documentation (letter from your doctor, brochures, notes, receipts, etc.) You may attach the certification from your treating provider if you are seeing an expedited review. Send to:

Blue Cross Blue Shield of Arizona
Medical Appeals and Grievances Department
P.O. Box 13466, Mail Stop A116
Phoenix, AZ 85002-3466
Phone 602-544-4938 or 1-866-595-5998
Fax 602-544-5601
Email: appeals@azblue.com

Signature of member or authorized representative _____ Date____/_____/_____

Provider Certification Form for Expedited Appeal

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You may use this form to explain the need for an urgent appeal, but you are not required to use it. Is the appeal for a service that the patient has not yet received? ☐ ***Yes*** ☐ ***No***

If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.
If "No," continue with this form.

Provider Information		
Treating Physician/Provider		
Phone #	Fax #	
Address		
City	State	ZIP Code

Patient Information		
Member Name		
Member ID #	Group #	
Phone #	Fax #	
Address		
City	State	ZIP Code

What service denial is the patient appealing? _____

_____

_____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient: _____

_____

_____

Fax this form with any supporting documentation and medical records to:
AZ Blue at **602-544-5601**

I certify, as the patient's treating provider, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health or ability to regain maximum function, or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature: _____ Date _____/_____/_____

Printed Name: _____

If you have questions about the appeals process or need help to prepare your Appeal, you may call AZ Blue at **1-866-287-1980.**

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-446-8331 (TTY: 711).

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-446-8331 (TTY: 711).

Navajo: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-800-446-8331 (TTY: 711).

Chinese Simplified: 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-446-8331（文本电话：711）。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-446-8331（TTY：711）。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-446-8331 (TTY: 711).

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-446-8331 (TTY: 711).

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-446-8331 (Người khuyết tật: 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-446-8331 (TTY: 711).

Korean: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-446-8331 (TTY: 711).

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-446-8331 (TTY: 711).

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) 1-800-446-8331.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-446-8331 (TTY: 711) ।

Farsi (Persian)

توجه: فارسي‌اگر همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. با شماره دسترس، به‌طور رایگان موجود می‌باشند. (تله‌تایپ: TTY: 711) 1-800-446-8331

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้
ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-446-8331 (TTY: 711)
หรือปรึกษาผู้ให้บริการของคุณ”

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-446-8331（TTY：711）。

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