Section 22

Provider Disputes and Complaints

Contents

Provider Dispute Resolution Processes – Overview

We value our network providers and work hard at being a good business partner. If and when disputes arise, we have processes in place to help resolve them. The nature of the dispute determines the specific resolution protocols:

1. **Credentialing disputes** related to a provider's professional competence or conduct, including:
   a. Terminations for professional competency or conduct, or quality-of-care issues (page 22-2)
   b. Immediate suspension or termination for concerns about member safety (page 22-3)
2. **Administrative disputes** involving matters not related to quality of care, including:
   a. Contract breaches related to administrative matters (page 22-5)
   b. Provider grievances regarding payment, timely filing, or systemic or operational problems (page 22-6)
   c. Medicare Advantage claim payment disputes (page 22-10)

Note: Some matters are not subject to dispute resolution. Under standard network participation agreements, both Blue Cross® Blue Shield® of Arizona (AZ Blue) and its network providers generally have certain rights to terminate without cause or not renew the agreement, for any number of business reasons. When AZ Blue or a provider decides to timely exercise those rights, there are no dispute, grievance, or reconsideration rights available to either party.

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Credentialing Disputes

1. CREDENTIALING DISPUTES – resolution process

a. Terminations for professional competency, conduct, or quality of care

Contracted providers may dispute AZ Blue's decision to terminate a contract for lack of professional competence or for professional misconduct. Examples of these disputes include, but are not limited to:

- Belief that a quality-of-care issue exists that may cause harm to a patient's health, welfare, or safety
- Adverse action taken by a hospital
- Disciplinary action taken by a licensing board
- Trend or pattern of quality-of-care issues

If a provider is terminated for professional competency or conduct:

1. AZ Blue will notify the provider in writing of the reason for the termination, including reference to the evidence (or documentation) supporting the termination. If applicable, we will enclose a copy of the AZ Blue Provider Appeals Process (for terminations related to quality-of-care issues), which includes detailed information about the provider's reconsideration rights and the right to be represented by legal counsel.

2. The provider may request **reconsideration** in writing (including relevant information) no later than 30 calendar days after receipt of notice of termination from AZ Blue.

   2a. A reconsideration panel consisting of at least three qualified individuals who did not participate in the original decision, with at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees, will review the reconsideration request at its next meeting (scheduled at least quarterly).

   2b. The panel will notify the provider in writing within seven calendar days of its decision, including the right to an in-person hearing.

3. If the provider is not satisfied with the panel's decision, the provider has 30 calendar days from receipt of the decision to request a **second-level reconsideration** (with relevant information and a personal appearance before a second panel).

   3a. A second panel of three individuals who did not participate in the first-level decision, including at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees, will hold the second-level reconsideration hearing. The panel will be convened no sooner than 60 calendar days before and no later than 90 calendar days after AZ Blue receives the provider's request, unless an extension is necessary (for up to an additional 60 calendar days). Written notice will be sent to the provider at least 60 calendar days prior to the date of the scheduled hearing.

   3b. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within seven calendar days of the decision.

Credentialing Disputes

b. Immediate suspension or termination related to concerns about member safety

If an AZ Blue medical director believes a provider is practicing in a manner that poses a significant risk to the health, welfare, or safety of members, AZ Blue can either immediately suspend or terminate the provider for cause.

- If the circumstances require an investigation for AZ Blue to know whether the concerns are justified, AZ Blue will immediately suspend the provider contract and conduct an expedited investigation.
- If the circumstances do not require an investigation for AZ Blue to know whether the concerns are justified, AZ Blue will immediately terminate the provider contract.
- Examples of circumstances that might result in immediate suspension or termination include, but are not limited to:
  - Insufficient or no professional liability insurance
  - Sanction by Medicare/Medicaid
  - Exclusion from any federal programs
  - A change in license status which prohibits the provider from practicing or places limitations that materially limit the provider's ability to provide a full range of medically necessary services to members.
  - Fraudulent activity

When a suspension or termination occurs:

1. AZ Blue will promptly remove the provider from the directory and send the provider written notice of the action and the reason for it, including reference to the evidence (or documentation) supporting the termination. If applicable, we will enclose a copy of the AZ Blue Provider Appeals Process (for terminations related to quality-of-care issues), which includes detailed information about the provider's available reconsideration rights (certain types of felony convictions cannot be appealed) and the right to be represented by legal counsel.

2. The provider has 30 calendar days from receipt of the notice to send AZ Blue a written request for **reconsideration** if the triggering event allows for reconsideration rights (certain types of felony convictions cannot be appealed). The request should include relevant information.

   2a. A reconsideration panel will review the reconsideration request at its next meeting (scheduled at least quarterly). The panel will have at least three qualified individuals who did not participate in the original decision, with at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees.

   2b. The panel will notify the provider in writing of its decision within seven calendar days after the meeting, including the right to an in-person hearing.

3. If the provider is not satisfied with the panel's decision, the provider has 30 calendar days from receipt of the decision to request a **second-level reconsideration** (with relevant information and a personal appearance before a second panel).

Credentialing Disputes

3a. A personal appearance panel will hold a second-level reconsideration hearing no sooner than 60 calendar days before and no later than 90 calendar days after AZ Blue's receipt of the request. The panel may extend the time period for up to an additional 60 calendar days, for good cause. Written notice will be sent to the provider at least 60 calendar days prior to the date of the scheduled hearing.

(The panel will have three individuals who did not participate in the first-level decision, including at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees.)

3b. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within seven calendar days of the decision.

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Administrative Disputes – Contract Breaches

2. ADMINISTRATIVE DISPUTES – resolution processes

Administrative disputes are different from disputes related to professional competence or conduct, or quality of care (see page 22-2). There are two types of administrative disputes:

a) **Provider contract breach** initiated when AZ Blue notifies a provider that the provider is in breach of the network participation agreement or a policy incorporated in the agreement; and

b) **Provider grievance** initiated by a provider due to disagreement or dispute with AZ Blue.

a. Provider contract breaches

A contract breach dispute can arise when a contracted provider wishes to protest AZ Blue's decision that the provider is in breach of obligations in the provider's participation agreement or an AZ Blue policy that is incorporated by reference in the provider's agreement. Examples of provider contract breach disputes include, but are not limited to:

- Non-compliance with administrative terms in the network participation agreement or Provider Operating Guide
- Billing a member in violation of the member hold harmless provisions of the agreement
- Failure to timely submit requested medical records
- Referrals to providers and use of facilities outside the member's network when network providers and facilities are available
- Defaming or falsely disparaging AZ Blue
- Directly or indirectly encouraging members to disenroll from an AZ Blue benefit plan and enroll in another payer's plan

AZ Blue will take appropriate action to address any breach of contract. If the provider does not cure the breach following notice from AZ Blue, it may result in contract termination.

If AZ Blue invokes the contractual right to terminate a provider's contract, we will initiate the administrative contract breach dispute resolution process described below.

Contract breach dispute resolution process following notice of a breach that remains uncured

1. AZ Blue will send a termination letter to notify the provider that the contract is terminated and provide information about the dispute resolution process and reconsideration rights.
2. The provider may request reconsideration in writing (including relevant information) no later than 30 calendar days after receipt of the notice from AZ Blue.
3. After the provider's reconsideration request is received, an authorized representative who was not involved in the initial decision giving rise to the dispute will review the written request for reconsideration and make a decision.
4. The authorized representative's decision is the final AZ Blue administrative decision and will be communicated to the provider in writing within 30 calendar days of receipt of the provider's written reconsideration request.

b. Provider grievances

AZ Blue supports three types of provider grievance processes. Only one process may be used to resolve a dispute.

1. **Disputes related to Medicare Advantage (MA) claim payments**
   These disputes are handled through the MA claim reconsideration process. For more information, see page 22-10.

2. **Disputes related to the initial payment for commercial and Federal Employee Program® (FEP®) claims that are in-scope for the No Surprises Act (NSA) negotiation/arbitration process,** including:
   - Out-of-network emergency services
   - Air ambulance services
   - Non-emergency services rendered by out-of-network providers at certain in-network facilities

   These disputes are resolved through the NSA negotiation/arbitration process. To the extent that AZ Blue is required by A.R.S. § 20-3102(F) to have a process for resolving payment disputes, AZ Blue has adopted the NSA process for all claims considered in-scope for the NSA as listed above. A non-participating provider may initiate the 30-day open negotiation process by submitting the NSA Claim Payment Negotiation Request form (available via our Appeals and Grievances page) along with a copy of the remit statement. Any dispute that is not settled within the 30-day period may be referred to an independent federal arbitrator.

3. **Disputes related to all other types of AZ Blue payment and administrative issues**
   These disputes are resolved through the AZ Blue grievance process in compliance with Arizona state law (ARS §§ 20-3101 and 20-3102).[1] All contracted and non-contracted providers may initiate the process by sending AZ Blue a written request (see optional provider grievance form on our Appeals and Grievances page). For more information about the provider grievance process, see the following pages (22-7 to 22-9). Grievance issues may include but are not limited to:
   - Whether a claim was clean
   - Timely filing (for details, see timely filing content in Section 19)
   - Failure to timely pay a claim
   - Amount paid (bundling software); Amount paid (other than bundling software)
   - Amount or timeliness of interest payment
   - Adjustment request
   - Network adequacy (other than the provider's contract status)
   - Systemic or operational problems
   - COB issues
   - Coinsurance/deductible
   - Sanction deductible
   - Fee schedule disputes
   - Outpatient global pricing
   - Fragmentation of incidental procedures
   - Modifiers

[1] Provider grievances arising out of services rendered to Federal Employee Program® (FEP®) members are not within the scope of the state law regarding provider grievances (ARS §§ 20-3101 and 20-3102). However, FEP does afford providers an independent right to grieve, as outlined here and on the following pages. FEP refers to provider grievance process as provider "appeals" or "reconsiderations."

Administrative Disputes – Provider Grievances

- Multiple medical/surgical procedure processing
- Procedure unbundling

Note: Please use the commercial member appeals process to challenge a decision involving how AZ Blue applied clinical criteria to determine medical necessity, appropriateness (including healthcare setting, level of care, or effectiveness of a covered benefit), or whether a service is considered experimental or investigational. For more information, see Section 23.

No claim corrections are permitted after a grievance is filed
Before submitting a grievance related to a claim, ensure that all information on the claim is accurate. A claim may not be corrected after a grievance has been filed. Grievance decisions are based on the premise that all information on the claim is accurate.

AZ Blue provider grievance process: First-level review
All grievances must be in writing (see grievance form on our Appeals and Grievances page) and submitted to AZ Blue no later than one year after the denial or other notification, or date of the occurrence if the provider did not receive notification. AZ Blue may extend this one-year time period for good cause or if a longer period is required by state or federal law. "Good cause," as used in this Section, means circumstances that were beyond the reasonable control of the provider and that prevented the provider from submitting a timely grievance request.

1. The provider sends a first-level grievance request to AZ Blue within the time frame explained above, including:
   - A reference to, or copy of, the action with which the provider disagrees
   - A written explanation of why the provider thinks the action is wrong, and the relief the provider is requesting
   - All necessary documentation that supports the provider's position, such as medical records, operative reports, or office notes
2. AZ Blue employees who were not involved in the initial determination review the grievance, including any new information submitted to AZ Blue.
3. AZ Blue sends the provider written notice of the grievance decision within 60 calendar days of receipt. For grievances related to claim payment, the notice may be in the form of a revised explanation of payment.

   AZ Blue may extend the 60-day time period for up to an additional 60 calendar days. If we require an extension, we will notify the provider in writing before the initial time period expires.

   AZ Blue will mail all decisions to the provider's last address on file, except for providers located outside of Arizona. We transmit decisions for out-of-state providers to the Blue Plan in the provider's home state, and that Blue Plan sends the decision to the provider. The decision is deemed received on the date of delivery, if hand delivered, or, if mailed, on the earlier of the actual date of receipt or five days after deposit in the U.S. mail, postage prepaid.

AZ Blue provider grievance process: Second-level review
A provider who is dissatisfied with AZ Blue's first-level grievance resolution may request a second-level grievance review. The second-level grievance must be submitted in writing to AZ Blue within 60 calendar days after receipt of the first-level grievance determination. A provider may extend the 60-day time period for up to an additional 60 calendar days by sending AZ Blue a written request for additional time, within the initial 60-day period.

Administrative Disputes – Provider Grievances

1. The provider sends the second-level grievance request to AZ Blue within the time frame explained above, including:
   - A written explanation of the reason for dissatisfaction with the prior decision
   - Any new supporting information for review
2. AZ Blue notifies the provider in writing of the final decision within 60 calendar days after AZ Blue receives the provider's second-level grievance request.

   AZ Blue may extend this 60-day time period for up to 30 calendar days on written notice to the provider, to be given within the 60-day period.

How to submit a provider grievance
You may use the Provider Grievance Form available on our Appeals and Grievances page to send a grievance and related documentation via email at ProviderDisputes@azblue.com or by fax at 602-544-5601.

For most plans, you may also send your written grievance and all necessary documentation to us at this address (see exceptions below):

AZ Blue Appeals and Grievances Department – Mailstop A116
P.O. Box 13466
Phoenix, AZ 85002-3466

For provider grievances related to:

- FEP claims or issues: Use Mailstop B205.
- CHS group claims or issues: Send the grievance and documentation to the group's third-party administrator (TPA) at the address listed on the remittance advice.
- Chiropractic claims or issues: See information below.

Other information regarding AZ Blue provider grievances

- **Situations not applicable to the grievance process**
  The provider grievance process does not apply to denial of admission to the AZ Blue network, termination from the network, or a complaint that is the subject of a member appeal under A.R.S. § 20-2530.
- **Appeals and grievances for members**
  The provider grievance process is distinct from the member appeal and grievance process and is not meant to limit provider participation in the member appeal process. Providers who are authorized to act on behalf of a member may submit an appeal to AZ Blue as permitted under the member appeal process and applicable state and federal law. For more information about member appeals, see Section 23.
- **Record requests**
  AZ Blue does not request records to support a grievance. Decisions are made on the basis of the information submitted with the grievance request, in combination with records previously received.
- **Delegated entities**
  AZ Blue may delegate responsibility for handling grievances for certain services to the vendors involved in administering those services.

  Chiropractic services administered by American Specialty Health (ASH)
  Chiropractic services are administered by ASH for most AZ Blue plans (see exceptions below), including administration of the dispute resolution process.

Administrative Disputes – Provider Grievances

Direct disputes to ASH at:

American Specialty Health (ASH), Attn: Appeals Coordinator
P.O. Box 509140
San Diego, CA 92150

Phone 1-800-972-4226 / Fax 1-877-248-2746

Exceptions:

- For disputes regarding chiropractic services (and related claims) for members of customized large group plans for which ASH is not the designated administrator, direct the dispute to AZ Blue.
- For disputes regarding chiropractic services (and related claims) for FEP members, direct the dispute to FEP.
- For disputes regarding chiropractic services (and related claims) for out-of-area BlueCard members, direct the dispute to AZ Blue.
- For disputes regarding chiropractic services (and related claims) for CHS group members, direct the dispute to the third-party administrator (TPA).

- **CHS group member and provider disputes**
  For CHS group members, direct all member appeals/grievances and provider grievances to the TPA at the address listed on the remittance advice. If the provider grievance is related to a specific pricing issue, the TPA will forward the grievance to AZ Blue to review and determine if an adjustment needs to be made. If so, AZ Blue will send the TPA a repriced claim. For more information about CHS groups, see Section 8.

ASH is a separate, independent company, contracted with AZ Blue to provide the chiropractic network, covered chiropractic services, and related claim processing and appeal/grievance resolution.

Medicare Advantage Claim Payment Disputes (Claim Reconsideration)

MA claim payment disputes are resolved through the **claim reconsideration** process. If you have validated that the information submitted on your claim is correct, but you disagree with and want to challenge a claim processing decision, you may request a reconsideration. We may also reconsider an adjudicated claim if we determine that the claim was incorrectly paid or denied.

Most claim adjustments and requests for reconsideration must be made within one year of the date the claim was originally processed. Exceptions to the one-year period are listed in Section 19.

How to request reconsideration

To avoid delays when requesting reconsideration, you must specify exactly what you want to have reconsidered. Along with a written description of your request, include a new claim form, the remittance advice (if applicable), medical records, and other supporting information necessary to review your request.

AZ Blue MA Claims Dept
P.O. Box 29234
Phoenix, AZ 85038-9234

Optum Health Network Arizona (OHNAZ)
Provider Dispute Resolution
P.O. Box 30539
Salt Lake City, UT 84130

Or: Email the PDR form to claimdispute@optum.com

Or: Call 1-877-370-2845 to file the dispute

Arizona Priority Care (AZPC)
Attn: Claims Department
585 N. Juniper Dr. Ste 200
Chandler, AZ 85226

MA reconsideration review process for claim payment disputes

All requests for reconsideration are reviewed within 60 calendar days from the date the request was received. Any resulting changes to claim payments or claim denials are made according to claim payment policies and procedures. If the original determination is upheld, a notification letter will be sent. If the original decision is reversed, payment will be made using the normal method and a new explanation of payment (EOP) will be sent.

Optum Health Network Arizona (OHNAZ) is a separate, wholly owned subsidiary of Optum and is contracted with AZ Blue to provide utilization management and claim/payment processing services for providers and attributed members with certain AZ Blue Medicare Advantage HMO plans.

Arizona Priority Care (AZPC) is a separate, independent company contracted with AZ Blue to provide healthcare services to AZ Blue providers and members. Arizona Priority Care is a service mark of Arizona Health Advantage, Inc.

Provider Complaint Process

Provider complaints

AZ Blue has incorporated formal mechanisms to address provider concerns and complaints. A complaint is defined as an expression of dissatisfaction with any of AZ Blue's products or services. Complaints may be submitted verbally or in writing.

In accordance with corporate policies and to support quality improvement, AZ Blue documents, analyzes, and maintains a record of provider complaints, concerns, and resolutions.

Examples of complaints include, but are not limited to, an expression of dissatisfaction regarding our medical policy or clinical criteria, the provider portal, service received from AZ Blue staff, or our products or services.

Complaints do **not** include:

- Member appeals and grievances
- Provider disputes handled within the dispute resolution processes described on pages 22-2 through 22-10
- General inquiries – e.g. "What is your mailing address?" or "What are the directions to your office?"
- Inquiries or requests to make a change
- Complaints related to regulatory compliance, fraud and abuse, or potential breach of confidential information or security (HIPAA violations); these are documented and managed within the scope of our compliance plan/program for follow-up, review/resolution, reporting, etc.
- Suggestions about how the organization can best serve its membership

Submitting a complaint

Providers may submit a formal complaint in any of the following ways:

- Contact your Provider Relations Contact
- Call Provider Assistance at 1-844-995-2583
- Call Provider Partnerships at 602-864-4231 or 1-800-232-2345, ext. 4231
- Email your complaint to ProvNet@azblue.com
- Fax your complaint to 602-864-3141
- Submit a written complaint to:

  Blue Cross Blue Shield of Arizona
  Attn: Provider Partnerships – Mailstop S102
  P.O. Box 13466
  Phoenix, AZ 85002