CHAPTER 9:
Provider Claim Appeals, Member Appeals and Member Grievances

Review/Revised: 1/21

9.0 ALTERNATIVES TO FILING A PROVIDER CLAIM APPEAL – FIRST STEPS TO CONSIDER BEFORE FILING A CLAIM APPEAL

Providers may resubmit claims that have been previously adjudicated by Health Choice Pathway and must be received by Health Choice Pathway within eighteen (18) months from the date of service.

9.0.1 Health Choice Pathway Claim Resubmissions

If your claim has denied due to needing additional information or corrections, it is considered a *Resubmission (i.e. missing medical records, an IZ form, not a clean claim, etc.)*.

Claim resubmissions should be sent back to the plan for reconsideration with a stamp or legible notice that the claim is a "Resubmission" and billed appropriately (see Chapter 7 section 7.12 of the HCA Provider Manual for additional reference on submitting resubmissions). If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim. Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the correct claim form with the services listed in detail.

All claim resubmissions can be mailed to:

Health Choice Pathway
Attn: Claims Department - Resubmissions
410 N. 44th St., Suite 900
Phoenix, AZ 85008

Health Choice Pathway will re-adjudicate claims resubmitted by providers only if initial claim had been filed within the prescribed submission timeframe.

Claims resubmissions must be designated as such and must consist of the following:

1. Copy of claim
2. Copy of Health Choice Pathway remittance advice
3. Supporting documentation
4. Written explanation as to reasons for resubmission

9.0.2 Health Choice Pathway Claim Reconsiderations

If your claim has denied due to reasons other than the above it is considered a *Reconsideration*. Provider requests for claims reconsideration must be received by Health Choice Pathway within eighteen (18 months) from the date of service or from the date of discharge for an in- patient hospital stay.

A Provider needs to provide in writing, a cover letter for each member's claim being disputed directly to Health Choice Pathway Claims Resubmission Department. Included with this cover letter should be a written explanation of the reason for the reconsideration, including a copy of the explanation of payment, documentation if appealing coding, or modifier use and medical records if needed.

Health Choice Pathway will make a determination within sixty (60) calendar days following receipt of the completed claims reconsideration cover letter.

All decisions rendered by Health Choice Pathway are final.

All Health Choice Pathway claim reconsiderations should be mailed to:

Health Choice Pathway
Attention: Claims Resubmission
410 N 44th St Suite 900
Phoenix, AZ 85008

All providers have the right to file a claim appeal in response to any adverse action or determination made by Health Choice Pathway. However, Health Choice Pathway encourages providers to exhaust all other means of resolution before using the claim appeal process.

Potential options prior to filing a claim dispute are:

- **Provider Portal**: The Provider Portal offers many features including 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 Health Choice Arizona Claims Resolution Services Unit at (800) 656-8991 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.

9.1 PROVIDER CLAIM APPEALS

Whenever possible, Health Choice Pathway attempts to informally resolve issues raised by contracted providers at the time of initial contact. If the issue cannot be resolved informally, Health Choice Pathway offers a two-level internal contracted provider payment review process for resolving disputes with contracted providers.

Below are the two-level provider payment review processes.

9.1.1 First Level Contracted Provider Payment Review

The first level of the contracted provider review process must be initiated by the practitioner/provider within 180 calendar days from the date of the plan determination (authorization or payment denial) by Health Choice Pathway.

The payment review request will be handled by a reviewer who was not involved in the initial decision. Decisions will be consistent with Medicare rules and regulations, the Provider's contract terms and/or the member's benefit plan.

Contracted Providers who are not satisfied with the first level review decision may request a second level provider payment review.

9.1.2 Second Level Contracted Provider Payment Review

The second-level of the contracted provider review process must be initiated by the practitioner/provider within 60 calendar days from the date of the first-level decision. Any request received after the 60 calendar day will automatically be upheld without further review.

The payment review request will be handled by a reviewer who was not involved in the initial decision or the first-level review. Decisions will be consistent with Medicare rules and regulations, the Provider's contract terms and/or the member's benefit plan.

Submit your appeal request to:

Health Choice Pathway
Attn: Provider Appeals/Disputes
410 N. 44th St., Suite. 900
Phoenix, AZ 85008

9.2 MEMBER APPEALS AND GRIEVANCES (COMPLAINTS)

Health Choice Pathway adopts Medicare requirements as they relate to member appeals and grievances (complaints). Health Choice Pathway will advise Providers of any member appeal or grievance relating to Providers' services under their Contract. Providers agree to cooperate with the Plan in the resolution of member requests for service, appeals and grievances, including, but not limited to, providing any information or records needed to render a decision on a request for service, appeal, or grievance. Providers will provide information and records with sufficient promptness to allow the Plan to meet CMS requirements for the timely processing of requests for service, appeals, and grievances. It is understood that certain requests for service and appeals must be processed by Plan, on an expedited basis, no later than seventy-two (72) hours of receipt. Providers will to the extent permitted by law, notify Health Choice Pathway of any Member appeal or grievance that relates to services provided under this Agreement.

9.3 MEMBER APPEALS FOR THE REDUCTION, SUSPENSION, OR TERMINATION OF AN AUTHORIZATION

A member may file an appeal with Health Choice Pathway in response to an adverse action such as the:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

The member must forward the appeal within sixty (60) days of the action. In addition to a member or a member's authorized representative, the member's primary care physician or other in-network physician can request an appeal of a denied prior authorization (Notice of Adverse Benefit Determination (NOA). A written appeal request must be received by Health Choice Pathway within 60 calendar days from the date of the original denial.

Appeal requests should be sent to the Appeals/Disputes Department:

Health Choice Pathway
Attention: Member Appeals
410 N. 44th St., Suite 900
Phoenix, AZ 85008

Appeal requests should be clearly marked as appeal and should be accompanied by justification and additional medical documentation supporting the request.

Once the Appeal process has been initiated, Health Choice Pathway will send the member an acknowledgment letter. Health Choice Pathway will respond to all appeals within thirty (30) calendar days from the date that the health plan received the request. Health Choice Pathway will mail a final written decision to the Member.

If an extension is necessary, Health Choice Pathway will notify the Member. Before we make our decision, your office can provide additional documentation to assist Health Choice Pathway in its determination of the Appeal.

If your office is filing an appeal on behalf of the member and a delay in processing could seriously jeopardize the member's the life, health or the ability to attain, maintain or regain maximum function your office can request an Expedited Appeal. In these instances the appeal will be decided within 72 hours from the date the appeal is received.

Extensions of up to 14 additional days can be requested by the member's provider or the Health Plan. If your office, the member, or Health Choice Pathway establishes the need for the additional days and delay is in the best interest of the member, an extension will be granted.

If Health Choice Pathway requests the extension, then Health Choice Pathway will call your office and the member, to notify you of the time and information needed to make a decision. Health Choice Pathway will also document the request in writing. If your office requires an extension to providing Health Choice Pathway with additional supporting documentation for the Member's appeal, please contact Health Choice Pathway by calling the phone number on the acknowledgement letter.

9.4 MEMBER GRIEVANCES (COMPLAINTS)

A member may file a Grievance (formerly a member Complaint) with Health Choice Pathway regarding the dissatisfaction with any aspect of their care (other than the appeal of any Notice of Adverse Benefit Determination (NOA). If a member wants to file a grievance, please direct him/her to Health Choice Arizona Member Services at (800) 656-8991, or inform him/her that he/she can submit his/her grievance in writing to:

Health Choice Pathway

Attention: Quality Management Department Member Grievance

410 N. 44th St., Suite 900

Phoenix, AZ 85008

If the grievance is against your office, Health Choice Pathway will contact you to get your input on the grievance.