APPEALS, RECONSIDERATIONS, PROVIDER GRIEVANCES AND MEMBER GRIEVANCES GUIDE

The **Provider Portal** is the fastest way to check status of a claim reconsideration.
You can also check status of a provider grievance or appeal by calling Customer Service.

Appeals, Reconsiderations and Provider Grievances

Appeals

When Ambetter from Arizona Complete Health denies a claim or authorization for a covered service, members receive information regarding the right to appeal the denial. The appeals process only occurs if the member or treating provider have specifically requested Ambetter from Arizona Complete Health review its initial decision. The member/treating provider/appointed representative has 2 years from the date of denial. The appeals process consists of the following levels of review:

For urgently needed services not yet provided:

- Expedited Medical Review
- Expedited Appeal
- Expedited External Independent Review

For standard services or denied claims:

- Initial Appeal
- External Independent Review

Appealable Health Plan decisions include:

- Health Plan does not authorize a service or pay for a claim because it is determined not medically necessary or not a covered benefit.
- Health Plan does not authorize a service or pay for a claim because it is determined to be experimental or investigational.
- Partial denials and reductions in level of care.
- Cancellation of the policy back to the effective date due to a reason other than failure to pay premiums, known as a rescission of coverage.

Treating providers are not required to obtain special permission to represent members in pre-service appeals proceedings.

To ensure that Ambetter from Arizona Complete Health processes the dispute correctly, to request a post service claim payment appeal on behalf of a Health Plan member; please complete the Provider Claim Dispute Resolution Form available in the resource section on our website:

ambetterhealth.com/en/az/provider-resources/manuals-and-forms

Reconsiderations

A claim reconsideration is an informal request for Ambetter from Arizona Complete Health to review a claim decision. Providers are highly encouraged to undertake this first step prior to filing a formal claim appeal or provider grievance. To submit a reconsideration, please submit via the secure **Provider Portal**.

You may also mail your claim reconsideration request to:

Ambetter from Arizona Complete Health
ATTN: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

- When submitting a reconsideration, the specific code or service being reconsidered must be listed on the request form.
- Providers have 1 year from the date of the denial to request a reconsideration.
- Claim denials for non-covered benefits must be addressed through the appeal process.
- Claim denials due to prior authorization not being obtained must follow the provider grievance process.
- Submit all substantiating documentation (please do not include image of claim) including a summary of the appeal, relevant medical records, and member-specific information.

NOTE: Ambetter does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

Ambetter from Arizona Complete Health is underwritten by Health Net of Arizona, Inc. (dba Arizona Complete Health), which is a Qualified Health Plan issuer in the Arizona Health Insurance Marketplace.

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Provider Grievances

Provider grievances are an expressed dissatisfaction about an issue that does not qualify as an appeal. There are 2 different levels of a Provider Grievance.

- Non-Claims Payment Related Provider Grievance
- Claims Payment Related Provider Grievance

Ambetter from Arizona Complete Health does not request records to support a grievance. Determinations are based on information submitted by the provider with the grievance request and records previously received.

Non-Claims Payment Provider Grievance

Examples include but are not limited to:

- Inaccurate and/or insufficient provider materials.
- Difficulty reaching assigned Provider Engagement Specialist to resolve issues.
- Lack of Health Plan responsiveness to requests for technical assistance.

Level 1: Non-Claims Payment Provider Grievance

- Providers may file a grievance not related to claims payment for up to 180 days after the incident.
- A written response is issued within 60 calendar days of the grievance filing.
- The Health Plan may extend the decision timeframe once for up to an additional 14 calendar days. Providers receive written notification of an extension.

Level 2: Non-Claims Payment Related Provider Grievance

- Providers have 60 calendar days from the date of the Level 1 response letter to file a Level 2 non-claims payment related grievance.
- Providers may extend the 60-day timeframe for up to an additional 60 calendar days if they provide the Health Plan written notification of the need for an extension within the initial 60-day period.
- Requests for Level 2 grievances should include an explanation of the dissatisfaction with the Level 1 decision and any applicable new information for consideration.
- The Health Plan mails the written response to Level 2 grievances within 60 calendar days of the grievance filing. The Health Plan may extend its 60-day review for an additional 60 calendar days. Providers receive written notification of an extension within the 60-day review period.

Claims Payment Related Provider Grievance

When a provider disagrees with the payment, or denial of a claim, and the issue can't be resolved via the claim resubmission or reconsideration process, the provider may initiate the provider grievance process. You may submit your claims payment provider grievance via the secure provider portal (preferred) or via the methods outlined on page 3.

Level 1 Claims Payment Related Provider Grievance

- Providers have up to 1 year from the date of denial to file a written claim related provider grievance.
- Written resolution is issued within 30 calendar days. If a decision is made to overturn the initial denial the Health Plan has an additional 30 days for claim effectuation.
- The Health Plan may extend the decision timeframe once for up to an additional 14 calendar days. Providers receive written notification of an extension.

Level 2: Claims Payment Related Provider Grievance

- Providers have 60 calendar days from the date of the Level 1 response letter to file a Level 2 non-claims payment related grievance.
- Providers may extend the 60-day time for up to an additional 60 calendar days if they provide the Health Plan written notification of the need for an extension within the initial 60-day period.
- Requests for Level 2 grievances should include an explanation of dissatisfaction with the Level 1 decision and any applicable new information for consideration.
- The Health Plan mails the written response for a Level 2 grievance within 60 calendar days of the grievance filing.
- The Health Plan may extend its 60-day review for an additional 30 calendar days. Providers receive written notification of an extension within the 60-day review period.

Expedited Medical Review Requests

For urgent (expedited) services, providers must first request an Expedited Medical Review on behalf of the member prior to submitting an Expedited Appeal. Providers must certify and provide supporting documentation that the standard appeal timeframe would be harmful to the member.

Mail, email or fax requests for *expedited medical review* with supporting documentation to:

Ambetter from
Arizona Complete Health
Request for Expedited Medical Review

Medical Request Address:
1850 W. Rio Salado Pkwy,
Suite 211
Tempe, AZ 85281

Pharmacy Request Address:
333 E. Wetmore
Road, Tucson, AZ 85705

Medical
Email: **AzCHPeerToPeer@azcompletehealth.com**
Fax: **1-833-214-5522** *(preferred)*

Pharmacy
Email: **AzCH.PharmacyLevel1Appeal@ azcompletehealth.com** *(preferred)*
Fax: **1-866-256-6046**

Appeals, Reconsiderations and Provider Grievances

Mail, email, or fax *reconsiderations* and *grievances (non-claim payment related and claim payment related)* with supporting documentation to:

Ambetter from
Arizona Complete Health
ATTN: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Email: **AzCHMarketplace2@azcompletehealth.com**
Fax: **1-866-461-7012**

Mail, email or fax medical *Appeals* with supporting documentation to:

Ambetter
Appeals and
Grievances Department
P.O. Box 10341
Van Nuys, CA 91410

Email: **AzCHMarketplace2@azcompletehealth.com**
Fax: **1-866-461-7012**

Submit *reconsiderations and claim payment related provider grievances* submission via Provider Portal

Reconsiderations and claim payment related provider grievances may also be submitted via the Provider Portal (preferred method)

azcompletehealth.com/login.html

Member Grievances

Member grievances may be filed verbally by contacting Customer Service or submitted in writing via mail, email or fax. Providers may also file a grievance on behalf of the member with the member's written consent. Appointment of Representative (AOR) form is available on our website: **ambetterhealth.com/en/az/resources/handbooks-forms**

Mail, email or fax *Member Grievances* to:

Ambetter
Appeals and
Grievances Department
P.O. Box 10341
Van Nuys, CA 91410

Email: **AzCHMarketplace2@azcompletehealth.com**
Fax: **1-877-615-7734**