ARIZONA CHIROPRACTIC SOCIETY

January 1, 2011

Health Care Provider Grievance Law

Arizona Department of Insurance

Office of the Director

REGULATORY BULLETIN 2006-021

Date: January 20, 2006

Provider Grievances: ARS § 20-3102(F) requires insurers to establish an internal system for resolving payment disputes and other provider grievances.

A. Purpose of Statutory Grievance System Requirements

This requirement is pivotal to the effectiveness of the timely pay and grievance law, especially because the new law "does not require or authorize the [Insurance] Director to adjudicate individual contracts or claims between health care insurers and health care providers." See ARS § 20-3102(H). Rather, the law places the duty on every insurer to establish an internal system for resolution of provider disputes. The Department's role is to verify that an insurer's grievance system is efficacious.

B. Characteristics of a Grievance

HB 2138 defines "grievance" as "any written complaint that is subject to resolution through the insurer's system that is prescribed in section 20-3102, subsection F and submitted by a provider and received by a health care insurer." See ARS § 20-3101(4). A grievance is not any of the following:

• A provider's complaint regarding denial of admission to an insurer's network.

See ARS § 20-3101(4)(a).
• A provider's complaint regarding termination from an insurer's network. See ARS § 20-3101(4)(b).
• A complaint that is the subject of a health care appeal under ARS § 20-2530 et seq. See ARS § 20-3101(4)(c).

Moreover, the HB 2138 definition of "grievance" is not limited to payment disputes, or to contracted provider grievances. Insurers may have payment disputes with both contracted and non-contracted providers and will need a grievance system that accommodates and reports payment disputes regardless of the contract status of the provider. At the same time, the grievance system must accommodate grievances from both contracted and non-contracted providers about matters other than payment disputes, including, but not limited to systemic or operational problems, quality assurance problems, or network adequacy problems unrelated to the provider's contract status.

C. Characteristics of an Internal Grievance System

The law reflects the legislature's intent that an insurer has both the opportunity and the operational ability to promptly correct its own mistakes. The Department recognizes that insurers' systems may vary, particularly depending on their product structure and networks, however, the Department expects an insurer's grievance system to be effective and to include the following basic characteristics: [4]

1. The insurer should describe its system in a written set of policies and procedures, readily available to providers on request. An insurer's grievance policy should specify the minimum information the insurer needs in order to resolve the grievance and the number of days in which the insurer will do so.

[4] The Department first set forth item nos. 1-4 in Circular Letter 2000-15; item nos. 5-7 provide the Department's answers to frequently asked questions.

2. Insurers should strive for an administratively simple system that: (a) providers can readily follow; (b) encourages providers to bring legitimate grievances; and, (c) provides for prompt dispute resolution.

3. The insurer representative responsible for resolving the grievance should be someone other than the person who made the initial decision giving rise to the grievance, and should be someone in a different chain of command (i.e. a neutral "third party").

4. The system should afford the provider a reasonable opportunity to present information related to the dispute, and to communicate with the decision maker, orally or in writing, as appropriate.

5. Insurers may encourage providers to use a particular form for certain grievances, but may not require them to do so. The Department will consider a communication as a grievance, even if its format is informal, or does not specifically use the words, "this is a grievance…"

6. A grievance is not dependent on nomenclature and insurers may use a term other than "grievance" to refer to grievances. Nonetheless, the Department encourages insurers to use the term "grievance," because, for example, referring to grievances as "appeals" increases the potential for confusion between a health care appeal and a provider grievance, or referring to grievances as "inquiries" may create a misleading impression regarding an insurer's duties to process such grievances according to law. See Section 5(D) "Grievances Distinguished from Health Care Appeals," below.

7. An insurer that has a tiered grievance process must record and report grievances to the Department beginning on the lowest tier. For example, an insurer may have a process which labels grievances as "inquiries". If the provider rejects the outcome of an inquiry, he or she may file an "appeal". If the provider does not like the outcome of an appeal, he or she may file a "grievance." Such a tiered system complies with ARS § 20-3102(F) as long as:
• The process is administratively simple (see Section 5(C), "Characteristics of an Internal Grievance System," above); and,
• The insurer records and reports the first tier "inquiry" as a grievance to the Department.

D. Grievances Distinguished from Health Care Appeals

The Department has received many questions about the difference between a health care appeal (HCA) and a provider grievance. The timely pay and grievance provisions set forth in ARS § 20-3101 et seq. neither limit nor expand the HCA process established under ARS § 20-2530 et seq.

The HCA process permits an enrollee to appeal if the insurer, having conducted utilization review, refuses to authorize a service, or pay a claim, because the insurer believes the service is not covered, or is not medically necessary. Providers often assist their patients in pursuing health care appeals and may pursue such appeals on behalf of patients. See ARS § 20-2530(1), which defines "member" to include an enrollee's treating provider. Providers appropriately acting on behalf of enrollees may bring a health care appeal of a payment denial to the extent allowed under the appeals process. See ARS § 20-2530 et seq.[5] On the other

[5] For a HCA, "'Claim' does not include claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers." A.R.S. § 20-2501(A)(3)(a). "'Denial' does not include enforcement of a health care insurer's deductibles or coinsurance requirement or adjustments for a service or coordination of benefits between health care insurers." A.R.S. § 20-2501(A)(5)(a).

hand, a provider should use an insurer's internal grievance system (established under ARS § 20-3102(F)) to: (1) submit, on his or her own behalf, grievances of the types listed in Attachment A hereto; and, (2) address payment denials relating to coverage, or medical necessity, that may not be subject to the HCA process.

6. Grievance Records

The law requires insurers to maintain records of provider grievances on a grievance-by-grievance basis. See Section 7(B), "Counting and Categorizing," below. The grievance records must include the information listed in ARS § 20-3102(F) and any additional information the Director requires.

A. Purpose of Semi-Annual Statutory Grievance Report

The Semi-Annual Statutory Grievance Report is a critical monitoring tool that provides the Department with important information about the insurer, its network, and its ability to pay claims and provide services to enrollees. It can serve as an indicator of, among other things, solvency problems, network inadequacies and quality assurance deficiencies.

B. Counting and Categorizing Grievances

For reporting as well as record-keeping purposes, an insurer must categorize each grievance it receives into one of eleven grievance types listed on Attachment A hereto. An insurer must separately treat each claim submitted as an individual grievance. For example, if a provider files a written notice that an insurer failed to pay interest on twenty late-paid claims, the insurer must

record that filing as twenty grievances, not one grievance. On the other hand, an insurer need not record more than one grievance per claim. For example, if a provider files a written notice that that an insurer made three errors processing one claim, the insurer need not record each error as a separate grievance, but may record the entire incident as a single grievance, categorized according to the provider's primary concern.

8. The Role of the Department

Providers should file original grievances with the insurer, not with the Department, however, the Department also encourages providers to send a copy of each grievance to the Department at:

Life & Health Division – TP&G Program
Arizona Department of Insurance
2910 North 44th Street, Suite 210,
Phoenix, Arizona 85018-7526

Neither providers nor insurers should address any information relating to enrollee health care appeals to the TP&G Program.

The Department monitors the grievance-related correspondence and calls that it receives from providers. Multiple grievances or calls related to a single insurer may indicate the insurer has systemic or other regulatory compliance problems. The Department uses the information in the Semi-Annual Statutory Grievance Reports to determine whether patterns exist that raise regulatory concerns.

If a provider contacts the Department regarding disputes more appropriately resolved through an insurer's statutory grievance process, the Department staff will educate the providers about the law and refer them to the insurer's provider grievance contact person. See Section 14, "Insurer Contact for Provider Grievances; Notice to the Department," below.

The Department has the authority to investigate complaints of alleged Title 20 violations that do not involve the adjudication of a claim, a grievance or a contract dispute. For example, if a provider alleges that an insurer frequently fails to resolve grievances, or fails to provide a copy of its grievance policy on request, the Department may investigate the complaint and will take appropriate measures to enforce Title 20.

The law does not provide any right of appeal *to the Department* for a provider dissatisfied with the results of an insurer's internal grievance system.