



STATE OF ARIZONA
DEPARTMENT OF INSURANCE

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Director of Insurance

Circular Letter 2000-15

TO:
FROM: Charles R. Cohen
DATE: November 9, 2000
RE: Timely Pay and Grievance Law

I. Introduction

"The Managed Care Accountability Act" [Laws 200, Ch. 37 (HB 2600)] establishes new requirements for health insurers' timely payment of health care provider claims, resolution by insurers of contract providers' other grievances, establishment of an internal grievance system, and reporting on health care provider grievances. The new provisions are summarized in Circular Letter 2000-6, p. 35. These provisions reflect legislative intent that timely

and accurate payment to health care providers is an essential component of a functional health care insurance system. If insurers fail to timely pay health care providers, it is potentially disruptive to patient care, to health care providers' relationships with their patients, and to insurers' health care provider networks. Timely payment of claims is also integral to a health insurer's fiscal soundness. The legislation further recognizes that health care providers have an obligation to submit clean claims that can be timely paid. Last, the legislation acknowledges that health care providers and insurers may contract for payment standards that vary from the minimum requirements set by statute.

This circular letter discusses how the Department will begin to implement the new requirements. It clarifies terminology used in the new law, addresses the conflict between the new law and existing statute, identifies minimum requirements for insurers' internal grievance systems, explains insurers' record-keeping and reporting obligations, establishes timelines for compliance, and outlines the role of the Department.

II. Scope and Application

The law applies to all health insurers, including:

- Disability (indemnity) insurers doing business in the group or individual markets;
- Service corporations governed by A.R.S. § 20-821 et seq.,

- Health care service organizations (HMOs) governed by A.R.S. § 20-1051 et seq.; and
- Prepaid dental plan organizations governed by A.R.S. § 20-1001 et seq.

The timely pay provisions of ARS § 20-3102 (A)-(E) apply to claims for dates of service beginning January 1, 2001. The grievance provisions of ARS § 20-3102 (F) and (G) and the payment adjustment provisions of ARS § 20-3102 (I) are effective January 1, 2001.

Types of Claims: The law contains no exclusions for particular types of claims. (Compare A.R.S. § 20-462(C) which has specific exclusions for Medicare claims.) Had the Legislature wished to exclude certain lines of insurance offered by insurers subject to the law, the Legislature could have done so as it did in A.R.S. § 20-462. Thus, A.R.S. § 20-3102 applies to all claims submitted to insurers subject to the law, absent some form of federal preemption such as the Federal Employment Program, payment of Medicare fee-for-service claims through a fiscal intermediary, or ERISA.

Providers: Although the term “health care provider” is not defined, the term “health care professional” is defined elsewhere in the bill. This latter term is limited in scope to individuals licensed under A.R.S. Title 32 or Title 36. By choosing the term “health care provider,” the Legislature chose a term that is subject to a more expansive interpretation than “health care professional.” The Department interprets the term “health care provider” to mean those persons who provide health or medical services or goods to an insurer’s policyholder, subscriber, member, or enrollee, including hospitals, health care professionals, suppliers of durable medical goods, and pharmacies, regardless of whether the health care provider is under contract with the insurer.

Third Party Intermediaries: The law applies to third party intermediaries (TPIs) as defined in A.R.S. § 20-120(K)(7). TPIs must approve or deny claims as prescribed in A.R.S. § 20-3101 et seq. If a health care insurer contracts with a TPI, that contract must require the TPI to comply with the timely payment requirements in A.R.S. § 20-3102.

III. Delegation of Authority

Health insurers often contract with unregulated third parties to perform health care provider claims functions and other administrative or network management functions. A health care insurer cannot escape responsibility under A.R.S. § 20-3101 et seq. by delegating such functions to a third party. Health care insurers are affirmatively responsible for monitoring the performance of the parties to whom they have delegated duties to ensure that the performance complies with the law. The Department will look to the health insurer, and will hold it responsible for the performance of other parties to whom the insurer has delegated its statutory responsibilities.

IV. Conflicts with Other Laws

A.R.S. § 20-462 is an older statute governing timely payment of first party claims. It applies to claims of a “provider who has been assigned the right to receive benefits

under the contract by the insured." A.R.S. § 20-462(D). It requires an insurer to pay interest on first party [clean] claims not paid within 30 days of the insurer's receipt of an acceptable proof of loss. Interest is payable from the date the insurer receives the clean claim.

The payment time period and interest accrual period in A.R.S. § 20-462 directly conflict with the new provisions of A.R.S. § 20-3102(A). Under the new law, and absent any different contractual provision, an insurer must simply approve a clean claim within 30 days of receipt. The insurer has an additional 30 days after approval to issue payment. Interest accrues from the payment due date rather than from the date the insurer received the clean claim.

Because A.R.S. § 20-3102 is later in time and more specifically governs the issue of health care provider payment, the new law controls, and supersedes A.R.S. § 20-462, as A.R.S. § 20-462 applies to the timing of payments to health care providers, as well as any implementing rule such as A.A.C. R20-6-801, and substantive policy statements such as circular letter 93-1. *Webb v. Dixon*, 104 Ariz.473, 455 P.2d 447, 449-50 (1969); *Alexander v. Fund Manager, Public Safety Personnel Retirement System*, 166 Ariz. 589, 804 P.2d 122, 126 (Ariz. App. 1990); *McLeod v Chilton*, 132 Ariz. 9, 643 P.2d 712,719 (Ariz. App. 1981).

Circular letter 93-1 is hereby expressly withdrawn. The Department reaffirms that the unfair claims practices act and any implementing rules apply to treatment of claims for reimbursement from enrollees who have sought and paid for out-of-network services.

V. Contractual Provisions

A.R.S. § 20-3102 also recognizes that an insurer and a health care provider may contract for a different payment period, an issue that was not addressed under A.R.S. § 20-462. If the health care provider and insurer have contracted for different payment provisions, the contract governs. However, failure to pay within some longer period specified by contract is still a violation of Title 20. An insurer and a health care provider are not free to enter into a contract that negates the effect of A.R.S. § 20-3101 et seq.

To illustrate, a health care provider and insurer may enter into a contract that allows the insurer to pay the health care provider within 60 days of acknowledgement of a clean claim, instead of the 30 days set forth in A.R.S. § 20-3102(A). Because the statute mandates that an insurer pay interest at the legal rate if the insurer fails to timely pay claims, the insurer and health care provider are not free to contract for a provision that excuses the insurer from any paying interest after that 60 day period. The legal rate, as defined in ARS § 44-1201, is ten percent per annum, unless a different rate is contracted for in writing.

A.R.S. § 20-3102 has no impact on contractual provisions that are not addressed by the statute, such as time periods for the submission of claims.

VI. Internal Grievance System

A.R.S. § 20-3102(F) requires insurers to establish an internal system for resolving payment disputes and other contractual grievances. This requirement is designed to afford health care providers some means to register a complaint against an insurer, as well as assurance that the complaint will be resolved.

The Department recognizes that the form of implementation may vary, depending on the type of insurer and the nature of its insurance products. For example, a disability insurer that issues only an indemnity product is less likely to have contracts with single health care providers. If an insurer does not have contracts with any health care providers (including PPOs) it may not be necessary for the insurer's grievance system to address "other contractual grievances."

Payment Disputes

The term "payment disputes" is not limited to contractual payment disputes. Insurers may have payment disputes with both contract and non-contract health care providers. Most insurers will need a grievance system that accommodates both types of health care providers, as to payment disputes.

Other contractual grievances

The insurer's grievance system must also accommodate grievances that contracted health care providers have about other issues arising out of their contracts. Such disputes may involve claims of retaliation for patient advocacy, quality assurance matters, such as the insurer's general practices and procedures for handling particular matters (e.g. premature hospital discharges), network adequacy matters or issues such as contract termination or contract modification.

Distinguishing Health Care Appeals

The timely pay and grievance provisions set forth in ARS § 20-3101 et seq. neither limit nor expand the health care appeals process established under A.R.S. § 20-2530 et seq. This process permits an insured to appeal if the insurer refuses to authorize a service or pay a claim because the insurer believes the service is not covered or is not medically necessary. Health care providers often assist their patients in pursuing a health care appeal and may pursue an appeal on a patient's behalf. See A.R.S. § 20-2530(1) which defines "member" to include an insured's treating provider.

Health care providers appropriately acting on behalf of members may bring a health care appeal of a payment denial to the extent allowed under the appeals process established in A.R.S. § 20-2530 et seq. Health care providers should use an insurer's internal grievance system established under A.R.S. § 20-3102 to address payment denials that are not subject to the health care appeals process.¹

¹ "‘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).

Standards

The law does not specify any standards for the grievance system. The Department recognizes that insurers' systems may vary, particularly depending on whether the insurer is a managed care organization or an indemnity insurer. However, the Department expects every insurer's grievance system to satisfy the following basic requirements:

- The system should be described in a written set of policies and procedures, which must be available to health care providers. Insurers should strive for an administratively simple system that can be managed by health care providers' office and administrative support personnel. An insurer's system should be simple and effective enough to encourage health care providers to bring legitimate grievances.
- The person 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.").
- In keeping with the purpose and the statutory requirements of the timely payment law, the system should be designed to promptly resolve disputes.
- The system should afford the health care provider a reasonable opportunity to present information related to the dispute, and to communicate with the decision-maker, orally or in writing, as appropriate.

VII. Insurer Contact for Provider Disputes; Notice to the Department

No later than Friday, December 8, 2000, each health care insurer is required to submit, to the Department, the name, title, address, telephone number, fax number, and e-mail address of a person or persons at the insurer who the insurer has designated as the primary recipient for health care provider grievances. Insurers shall also provide the Department with the mailing address for health care provider grievances.

An insurer shall notify the Department, in writing, in advance of any changes in the information submitted above, unless advance notice is impracticable (such as when a contact person quits without notice or is terminated.) In such cases, the insurer should notify the Department as soon as possible.

When the Department is contacted by a health care provider who is complaining about a matter that is appropriate for resolution through the insurer's grievance process, the Department will advise the health care provider to submit the complaint in writing to the address designated by the insurer. The Department will also advise the health care provider that he or she may contact the individual designated by the insurer.

Insurers should submit this information to the Department's Life and Health Division, 2910 North 44th Street, Suite 210, Phoenix, Arizona 85018-7526.

VIII. Grievance Records and Summary

Grievance records

The law requires insurers to maintain records of health care provider grievances on a grievance by grievance basis. The grievance records must include at least a minimum of information listed in A.R.S. § 20-3102(F). The Insurance Director may require insurers to keep records of information in addition to the statutory elements.

Statutory record-keeping requirements:

- Name of health care provider
- Health care provider identification number (must be health care provider's tax identification number)
- Type of grievance (see categories listed and described below)
- Date health care provider filed grievance
- Date grievance resolved (that is, the date the insurer mails notice of resolution to the health care provider).

Additional record-keeping requirements:

- Any records necessary to support the semi-annual summary report described below.
- Number of grievances, if any, pre-empted under HCFA guidelines for Medicare+Choice appeals and grievances as to coverage determinations.

Grievance Report

The law requires insurers to semi-annually file with the Department a grievance report that summarizes all grievance records. The grievance report is a critical monitoring tool and will provide the Department with important information about the insurer, its network, and its ability to pay claims and provide services to members. It can serve as an indicator of solvency problems, network inadequacies, and quality assurance deficiencies within the insurer.

Timing of reports:

Reports are due each October 1 for grievances filed between January 1 and June 30, and each April 1 for grievances filed relating to dates of service between July 1 and December 31. Reports filed on October 1 should include all data available about resolution of grievances filed between January 1 and June 30 and resolved on or before August 31. Reports filed on April 1 should include all data available about resolution of grievances filed between July 1 and December 31 and resolved on or before February 28 (or February 29, if applicable).

Format and content of the report:

Insurers' grievance reports should be broken out by type of grievance (see the categories listed and described below) and by zip code for geographical reference. The reports should summarize the number of grievances filed, the forms of resolution, the average number of days to resolution and, where the grievance involves a dispute over the amount paid, the average amount in dispute per such grievance. Format and

content specifications for the electronic submission of data are provided in Attachment A to this Circular Letter.

Types of Grievances

To qualify as a grievance subject to reporting requirements, the grievance must be a health care provider complaint that is submitted to the insurer in writing². For the report to be an accurate measure of insurers' performance, it is vital that all insurers categorize and report grievances in the same manner.

Timely payment grievances

Grievances over timely payment must be categorized as one of the following:

- Grievance Type 1: Clean claims. (The insurer and the health care provider disagree over whether the health care provider has submitted a clean claim or responded to a request for more information.)
- Grievance Type 2: Untimely claims submission. (Denial based on health care provider not submitting the claim for payment within the time period prescribed in the health care provider's contract; if the health care provider has no contract, within a 24 month period of the last date of service.)
- Grievance Type 3: Dispute over amount paid.
- Grievance Type 4: Denial of payment based on lack of insurance contract coverage. (The service was not covered under the policy).
- Grievance Type 5: Denial of payment based on lack of patient eligibility. (The patient was not an enrollee/member/subscriber/policyholder at time of service).
- Grievance Type 6: Denial of payment based on lack of medical necessity.
- Grievance Type 7: Denial based on lack of pre-authorization or notification of service.
- Grievance Type 8: Action inconsistent with pre-authorization. (The service was preauthorized, but insurer subsequently denied payment or reduced payment.)
- Grievance Type 9: Failure to timely pay claim. (Within 30 days or within contract period.)
- Grievance Type 10: Dispute over amount or timeliness of interest payment.
- Grievance Type 11: Denial of adjustment requested within one year of payment.
- Grievance Type 12: Denial or payment reduction based on coordination of benefits.
- Grievance Type 13: Grievance resolution not implemented by the insurer. (For example, payment not made after resolution of a grievance in favor of the health care provider).
- Grievance Type 14: Other timely pay issue.

² As noted above, the Department urges insurers to adopt administratively simple grievance procedures. The Department expects that insurers will not attempt to discourage grievances or deflate grievance numbers by setting an unrealistically high bar for what constitutes a reportable grievance. For example, while a provider's telephonic inquiry about the status of a particular billing may not rise to the level of a grievance, if the health care provider puts the complaint in writing and says that he or she is challenging the insurer's decision to deny payment, the insurer must treat this as a reportable grievance even though the health care provider did not use the words "I am grieving..." An insurer cannot mandate use of particular forms or magic language before a health care provider complaint rises to the level of a reportable grievance. The insurer's policies and procedures must specify what is required for submission of a grievance.

Other contractual disputes:

- Grievance Type 15: Retaliation for patient advocacy.
- Grievance Type 16: Disputes over patient load or assignments. (Health care provider asserts that it cannot accept any more patients from the insurer or health care provider claims that patient load is disproportionately high risk.)
- Grievance Type 17: Systemic operational or quality assurance issues. (Disputes over operational or patient care policies and procedures that are not related to the care and particular circumstances of an individual patient, for example, delay in processing requests for authorization; pattern of premature hospital discharges; insufficient level of care routinely imposed; appropriate patient education referrals limited or denied.)
- Grievance Type 18: Network adequacy. (For example, no specialist referrals available in local area).
- Grievance Type 19: Dispute over contract terms. (For example, arbitration, termination, modifications, etc.)
- Grievance Type 20: Grievance resolution not implemented.
- Grievance Type 21: Other issue.

IX. The Role of the Department

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.” A.R.S. § 20-3102(H). The bill did not appropriate any new resources to the Department to enable it to facilitate resolution of payment and other health care provider disputes. Rather, the law places the duty on insurers to establish an internal system for resolution of these disputes. The law does not provide any right of appeal to the Department for health care providers who are dissatisfied with the results of an insurer’s internal grievance system.

If health care providers contact the Department regarding disputes over matters that are appropriately resolved through an insurer’s grievance process established pursuant to A.R.S. § 20-3101 et seq., Department staff will refer health care providers to the contact person designated by the insurer. This will include disputes over whether a claim is a clean claim, disputes over the amount that should be paid, and disputes over whether the claim has been timely paid.

The Department will continue to monitor calls received from health care providers. In the past, the Department has found that multiple calls related to a single insurer may indicate systemic problems with that insurer.

In addition, the Department will receive insurers’ semiannual grievance system reports, and make them available pursuant to public records laws. The Department will review and analyze the information in the report, and assess whether the reports indicate patterns that raise regulatory concerns. The Director may examine an insurer if the reports show a “significant number” of unresolved grievances, or otherwise suggest the need for it.

Some health care providers may contact the Department to assert complaints alleging Title 20 violations that do not require the adjudication of a contract dispute. For example, if a complaint alleges that an insurer has failed to establish an internal grievance process for health care provider disputes, the Department will investigate the allegation as a Title 20 violation, and will take appropriate measures to enforce Title 20.

Any person who has questions regarding this circular letter may contact Alexandra Shafer, Assistant Director of the Department's Life and Health Division, at 602-912-8460.

ATTACHMENT A
SPECIFICATIONS FOR GRIEVANCE REPORT

The Grievance Report should be provided in two ASCII text files, in comma delimited format (AKA Comma Separated Values "CSV").

Grievance Statistics File

Each line of the Grievance Statistics File will include the summary information for a specified zip code and grievance type and contain the following data:

Insurer NAIC #.
Reporting Year.
Reporting Period (1=Jan to June; 2=July to December).
Zip Code of Summary
Grievance Type (1-21)
Total number received.
Total number resolved: Insurer position upheld.
Total number resolved: Insurer position reversed.
Total number resolved: Insurer position modified.
Total number resolved: Grievance withdrawn.
Total number resolved: Other.
Average number of days to resolve.
Average \$ amount in dispute per grievance.*

*Average \$ amount in dispute only applicable to Grievance Type 3 - all others should report \$0.

The Grievance Statistics File should be named in the following fashion:

G#####.CSV, where "#####" = insurer NAIC number

For example, the file for an insurer with NAIC number 00000 would be G00000.CSV.

Health Care Provider Grievance File

The Health Care Provider Grievance File should contain one line of data, containing the following three state-wide grievance numbers as filed by all health care providers:

Total number of Grievances: Category - Professional
Total number of Grievances: Category - Facility
Total number of Grievances: Category - Ancillary

The Health Care Provider Grievance File should be named in the following fashion:

H#####.CSV, where "#####" = insurer NAIC number

For example, the file for an insurer with NAIC number 00000 would be H00000.CSV.