ROLE OF THE DEPARTMENT

The law does not provide the Department with the authority or resources to adjudicate individual claims or contracts between insurers and providers. Rather, the Legislature mandated the grievance system for provider disputes.

1. Providers should send grievance(s) directly to the insurer. They may copy the Department's Timely Pay & Grievance Analyst for information purposes.
2. If a provider contacts the Department about an unpaid claim or other grievance, the Department will refer the provider to the insurer's designated Grievance Contact Person.
3. The Department monitors the copies of grievances it receives from providers as well as the insurers' semi-annual grievance reports.
4. Providers that are unable to get a copy of an insurer's written grievance policy from an insurer, or who need the name of an insurer's grievance contact person, may contact the Department for assistance.

The Department only has authority to enforce the Timely Pay & Grievance law as it applies to payors under the Department's jurisdiction. The following payors are NOT under the Department's jurisdiction:

AHCCCS (Medicaid)
Medicare
Worker's Compensation
Federal Employee Benefit Programs
County/Municipal Health Systems
Self-Insured Employer Plans
Insurers Not Authorized in Arizona

FOR MORE INFORMATION:

www.id.state.az.us

Timely Pay & Grievance History:

HB2600 (effective January 1, 2001)

HB2138 (effective January 1, 2006)

Timely Pay & Grievance Statutes:

A.R.S. § 20-3101

A.R.S. § 20-3102

Regulatory Bulletin:

Regulatory Bulletin 2006-02

QUESTIONS?

Arizona Department of Insurance

2910 N. 44th St., #210
Phoenix, AZ 85018

Phone: (602) 364-2394
Fax: (602) 364-2175

Email: providerinfo@id.state.az.us

January 2009

Persons with disabilities may request that materials be presented in an alternative format by contacting the ADA Coordinator at (602) 364-3100. Requests should be made as early as possible to allow time to procure the materials in an alternative format.

Timely Pay & Grievance Law

Information for Health Care Providers

Janice K. Brewer, Governor
Christina Urias, Director

Arizona Department of Insurance

Life & Health Division

In 2000, the Arizona Legislature passed House Bill 2600, creating the Timely Pay & Grievance law, governing the timely payment of health care provider claims. The law requires health care insurers to establish a system for processing disputes between providers and insurers.

In 2005, the Legislature passed HB 2138, which has added definitions to the law and clarified requirements for claims processing, grievance systems, and payment adjustments.

This pamphlet from the Arizona Department of Insurance summarizes the Timely Pay & Grievance law and explains what assistance is available from the Department for health care providers.

CLAIMS PROCESSING

1. A clean claim is one that an insurer can process without obtaining additional information, including coordination of benefits information.

2. If a claim is not clean, and an insurer requires additional information, the insurer must send a written request for the information within 30 days of receipt of the claim or within a time frame designated by contract. The insurer must specify the reason(s) it cannot adjudicate the claim.

3. An insurer must record the date it receives any additional information that the insurer requested.

4. An insurer may not require a provider to submit information a provider can document it has already provided, unless the insurer can provide reasonable justification and the purpose is not to delay the claim.

5. The Department expects insurers to have a written policy available to providers that describes how providers may document they have already submitted the information the insurer wants them to resubmit.

ADJUDICATION AND PAYMENT

1. Under the law, adjudication and payment of clean claims are two separate steps. "Adjudication" means to make a decision on whether to pay or deny, in whole or in part, including the decision on the amount to pay.

2. Insurers must adjudicate clean claims within 30 days of receipt, or within a time frame designated by contract.

3. Insurers must pay any approved portions of clean claims within 30 days of adjudication, or within a time frame designated by contract.

4. Insurers that do not pay clean claims on time must pay interest at 10% per annum or another amount designated by contract. Interest begins accruing on the date payment is due.

ADJUSTMENTS

1. Neither an insurer nor a provider may request an adjustment of a claim more than one year after an insurer has paid or denied the claim.

2. An insurer and provider may designate a different time limit for adjustment by contract provided that limit applies equally to the insurer and to the provider.

GRIEVANCES

A provider grievance is any written complaint subject to the Timely Pay & Grievance law, except:

- A complaint by a non-contracted provider about not being in an insurer's network.

- A complaint by a provider about an insurer's decision to terminate the provider from the insurer's network.

- An issue subject to health care appeals laws governing benefit coverage and/or medical necessity (A.R.S. § 20-2530 et seq.) *See the Department's website for a separate brochure on the health care appeals laws.*

INSURER GRIEVANCE SYSTEMS

Each insurer:

- Must have a written grievance policy that is available to providers upon request.

- Must designate a contact person to receive grievances and answer provider questions on those grievances.

- May recommend, but may not require, a specific form for the submission of grievances.

- Must submit semi-annual grievance reports to the Department, which include information such as the number of grievances received by an insurer, the kinds of grievances, and the time to resolution.

NOTES

The Timely Pay and Grievance law:

- Applies to both contracted and non-contracted providers.

- Has no impact on contractual or policy provisions which are not addressed by the statute (such as time periods for initial claim submission).