

SECTION VIII: Claim Disputes and Appeals

PROVIDER CLAIM DISPUTES & APPEALS

Care1st encourages providers to check claim status on our website www.care1st.com/az or contact Claims Customer Service for assistance with questions or issues regarding claim payment, partial payment, or non-payment. As a reminder, initial claim submissions must be received within six months from the date of service. A claim payment, payment reduction or claim denial may be disputed by filing a claim dispute.

A Claim Dispute is:

1. a formal legal challenge of a health plan's disposition of a claim
2. the final means afforded to a provider to resolve a claim determination
3. a time sensitive process that is without exception

A Claim Dispute is not:

1. an alternate claim submission or resubmission process
2. a billing and or write off requirement
3. a means for a contracted provider to seek an exception of claims rules

AHCCCS guidelines require that all claim disputes (i.e. complete or partial denial of a claim) be submitted in writing within 12 months from the date of service; the date of discharge (for an inpatient claim); or within 60 days of the last adverse action, whichever is greater. A provider should never wait longer than the required timeframes to file a dispute: however, **providers are encouraged to exhaust all other available means of resolving an issue before filing a dispute.**

All requests for dispute should include:

1. A completed claim dispute form OR a letter detailing the factual and legal basis for the dispute.
(If submitting Care1st Claim Dispute Form, please use one Claim Dispute Form for each disputed claim. The Claim Dispute Form is available on our website in the "Forms" section of the Provider menu or by contacting Provider Network Operations.)
2. A copy of the original claim and remittance advice
3. Supporting documentation for reconsideration. For provider disputes with a clinical component (such as denied inpatient days, or services denied for no prior authorization), additional documentation should include a narrative describing the situation, an operative report and medical records as applicable.

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4. Mail the completed form(s) and documentation to:

**Care1st Health Plan Arizona
Claim Disputes and Appeals
2355 East Camelback Road, Ste 300
Phoenix, AZ 85016**

Note: Disputes that fail to detail the facts of the case, the legal argument or are submitted with incomplete information will be denied without medical review. Care1st will not attempt to solicit supporting documentation.

PROCEDURE

- Care1st acknowledges claim dispute requests within five business days of receipt. If you do not receive an acknowledgement letter you should contact the Claim Disputes & Appeals Team to inquire about the status of the matter immediately.
- Disputes are reviewed and a decision issued within 30 calendar days of receipt (15 calendar days for DDD). Care1st may take an extension of up to 30 calendar days, if necessary to completely review the disputed matter.
- Care1st issues ALL decisions, whether approved or denied, in writing.

If a provider disagrees with the resolution of a matter, a request for State Fair Hearing may be filed in writing, and within 30 days from the date of receipt of the Care1st denial. The process for requesting a hearing will be provided in the decision letter. When a request for State Fair Hearing is received, the plan will duplicate the case file and forwarded it to the AHCCCS Office of Legal Assistance who will either schedule an administrative hearing or render an “informal decision.” The provider will be notified by the AHCCCS Office of Legal Assistance of hearing dates, times and locations. AHCCCS administrative hearings are conducted by an Administrative Law Judge at the Office of Administrative Hearings. At the conclusion of the hearing, the Administrative Law Judge will issue a recommended decision to the AHCCCS Administration, who will then issue a final determination.

MEMBER APPEALS

A provider may appeal, on behalf of a member with the member’s written consent or may direct the member to the Member Services Department for appeal submission.

Members may appeal telephonically, in person, or in writing within 60 days of the adverse action. Expedited Member Appeals are resolved in three business days while standard appeals are resolved in 30. An extension of up to 14 days may be taken, if required to fully investigate the matter.

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All Member Appeals are mailed to:

**Care1st Health Plan Arizona
Claim Disputes and Appeals
2355 East Camelback Road, Ste 300
Phoenix, AZ 85016**

Note: All Claim Disputes and Appeals are tracked for trends, however no action is ever taken against a provider who files a claim dispute, supports an enrollee's appeal or advocates on behalf of the member.