9 Claims Disputes, Member Appeals, and Member Grievances

ALTERNATIVE TO FILING A DISPUTE
(FIRST STEPS TO CONSIDER BEFORE FILING A DISPUTE)

HEALTH CHOICE GENERATIONS CLAIMS RESUBMISSIONS

Providers may resubmit claims that have been previously adjudicated by Health Choice Generations and must be received by Health Choice Generations within eighteen (18) months from the date of service.

If your claim has denied due to needing additional information or corrections, it is considered a *Resubmission (i.e. missing medical records, an IZ form, not a clean claim, etc.)*. Claim resubmissions should be sent back to the plan for reconsideration with a stamp or legible notice that the claim is a "Resubmission". If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim. Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the correct claim form with the services listed in detail.

All claim resubmissions can be mailed to

Health Choice Arizona
Attn: Claims Department - Resubmissions
410 N. 44th St., Ste 510
Phoenix, AZ 85008

Health Choice Generations will re-adjudicate claims resubmitted by providers only if initial claim had been filed within the prescribed submission timeframe.

Claims resubmissions must be designated as such and must consist of the following:
1. Copy of claim
2. Copy of Health Choice Generations remittance advice
3. Supporting documentation
4. Written explanation as to reasons for resubmission

HEALTH CHOICE GENERATIONS CLAIMS RECONSIDERATION

If your claim has denied due to reasons other than the above it is considered a *Reconsideration*. Provider requests for claims reconsideration must be received by Health Choice Generations within eighteen (18 months) from the date of service or from the date of discharge for an in- patient hospital stay. Provider need to provide in writing a cover letter for each member's claim being disputed directly to Health Choice Generations Claims Resubmission Department. Included with this cover letter should be a written explanation of the reason for the reconsideration, including a copy of the explanation of payment, documentation if appealing coding, or modifier use and medical records if needed.

Health Choice Generations will make a determination within sixty (60) calendar days following receipt of the completed claims reconsideration cover letter. All decisions rendered by Health Choice Generations are final.

All Health Choice Generations claim reconsiderations should be mailed to:

Health Choice Generations HMO
Attention: Claims Resubmission
410 N 44th St Ste 510
Phoenix, AZ 85008

PROVIDER APPEALS

Whenever possible, Health Choice Generations attempts to informally resolve issues raised by contracted providers at the time of initial contact. If the issue cannot be resolved informally, Health Choice Generations offers a two-level internal contracted provider payment review process for resolving disputes with contracted providers. Below are the two-level provider payment review processes.

FIRST LEVEL CONTRACTED PROVIDER PAYMENT REVIEW

The first level of the contracted provider review process must be initiated by the practitioner/provider within 180 calendar days from the date of the plan determination (authorization or payment denial) by Health Choice Generations.

The payment review request will be handled by a reviewer who was not involved in the initial decision. Decisions will be consistent with Medicare rules and regulations, the Provider's contract terms and/or the member's benefit plan.

Contracted Providers who are not satisfied with the first level review decision may request a second level provider payment review.

SECOND LEVEL CONTRACTED PROVIDER PAYMENT REVIEW

The second-level of the contracted provider review process must be initiated by the practitioner/provider within 60 calendar days from the date of the first-level decision. Any request received after the 60 calendar day will automatically be upheld without further review.

The payment review request will be handled by a reviewer who was not involved in the initial decision or the first-level review. Decisions will be consistent with Medicare rules and regulations, the Provider's contract terms and/or the member's benefit plan.
Submit your appeal request to:

Health Choice Generations HMO
Attn: Provider Appeals/Disputes
410 N. 44th St., Ste. 510
Phoenix, AZ 85008

MEMBER APPEALS and GRIEVANCES (COMPLAINTS)

Health Choice Generations adopts Medicare requirements as they relate to member appeals and grievances (complaints). Health Choice Generations will advise Providers of any member appeal or grievance relating to Providers' services under their Contract. Providers agree to cooperate with the Plan in the resolution of member requests for service, appeals and grievances, including, but not limited to, providing any information or records needed to render a decision on a request for service, appeal, or grievance. Providers will provide information and records with sufficient promptness to allow the Plan to meet CMS requirements for the timely processing of requests for service, appeals, and grievances. It is understood that certain requests for service and appeals must be processed by Plan, on an expedited basis, no later than seventy-two (72) hours of receipt. Providers will to the extent permitted by law, advise Health Choice Generations of any Member appeal or grievance that relates to services provided under this Agreement.

MEMBER APPEALS FOR THE REDUCTION, SUSPENSION, OR TERMINATION OF AN AUTHORIZATION

A member may file an appeal with Health Choice Generations in response to an adverse action such as the:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;

- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

The member must forward the appeal within sixty (60) days of the action. In addition to a member or a member's authorized representative, the member's primary care physician or other in-network physician can request an appeal of a denied prior authorization (Notice of Adverse Benefit Determination (NOA). A written appeal request must be received by Health Choice Generations within 60 calendar days from the date of the original denial. Appeal requests should be sent to the Appeals/Disputes Department:

Health Choice Generations HMO
Attention: Member Appeals
410 N. 44th St., Ste 900
Phoenix, AZ 85008

Appeal requests should be clearly marked as appeal and should be accompanied by justification and additional medical documentation supporting the request.

Once the Appeal process has been initiated, Health Choice Generations will send the member an acknowledgment letter. Health Choice Generations will respond to all appeals within thirty (30) calendar days from the date that the health plan received the request. Health Choice Generations will mail a final written decision to the Member. If an extension is necessary, Health Choice Generations will notify the Member. Before we make our decision, your office can provide additional documentation to assist Health Choice Generations in its determination of the Appeal.

If your office is filing an appeal on behalf of the member and a delay in processing could seriously jeopardize the member's the life, health or the ability to attain, maintain or regain maximum function your office can request an Expedited Appeal. In these instances the appeal will be decided within 72 hours from the date the appeal is received.

Extensions of up to 14 additional days can be requested by the member's provider or the Health Plan. If your office, the member, or Health Choice Generations establishes the need for the additional days and delay is in the best interest of the member, an extension will be granted. If Health Choice Generations requests the extension, then Health Choice Generations will call your office and the member, to notify you of the time and information needed to make a decision. Health Choice Generations will also document the request in writing. If your office requires an extension to providing Health Choice Generations with additional supporting documentation for the Member's appeal, please contact Health Choice Generations by calling the phone number on the acknowledgement letter.

(COMPLAINTS)

A member may file a Grievance (formerly a member Complaint) with Health Choice Generations regarding the dissatisfaction with any aspect of their care (other than the appeal of any Notice of Adverse Benefit Determination (NOA). If a member wants to file a grievance, please direct him/her to Health Choice Arizona Member Services at 1-800-656-8991, or inform him/her that he/she can submit his/her grievance in writing to:

Health Choice
Generations
Attention: Quality Management Department Member
Grievance
410 N. 44th St., Ste 900
Phoenix, AZ 85008

If the grievance is against your office, Health Choice Generations will contact you to get your input on the grievance.

Reviewed/Revised: 12/21/2017, 10/10/2017, 02/01/2017, 02/15/2016, 09/16/2015, 01/14/2014