



**Pascua Yaqui T/RBHA
CENTERED SPIRIT PROGRAM
Policy and Procedure Manual**

Section 5.6 **Provider Claims Disputes**

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I. STATEMENT OF PURPOSE

This applies to all providers with or without a contract with a T/RBHA who provide services to persons enrolled in the ADHS/DBHS behavioral health system. The policy is to ensure that providers understand the procedures for filing and resolving claim disputes.

The provider claim disputes process affords behavioral health providers the opportunity to challenge a decision by the Tribal or Regional Behavioral Health Authority (T/RBHA) or Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) that impacts the provider. Behavioral health providers may dispute issues involving:

A payment of a claim;

The denial of a claim; and

The imposition of sanctions.

Behavioral health providers will initially file a claim dispute directly with either a Regional Behavioral Health Authority (RBHA) or ADHS/DBHS, depending upon:

Which entity is responsible for the decision; and/or

If a claim payment issue, if the dispute involves services to a person enrolled with a T/RBHA.



Behavioral health providers initially submit a claim dispute to a RBHA when:

Challenging a decision of the RBHA; or

Disputing a claim payment issue for services provided to persons enrolled with a RBHA.

Behavioral health providers initially submit a claim dispute to ADHS/DBHS when:

Challenging a decision of ADHS/DBHS; or

Disputing a claim payment issue for services provided to persons enrolled with a T RBHA.

Once the RBHA or ADHS/DBHS makes a decision regarding a provider claim dispute, the behavioral health provider may request another review of the decision, referred to as an administrative hearing.

Many times, disagreements between a behavioral health provider and the RBHA or ADHS/DBHS can be resolved through an informal process. Behavioral health providers are encouraged to try and solve issues at the informal level before initiating the formal provider claim dispute process. However, providers should be aware that the formal process contains very specific timeframes within which to file for a review and/or hearing and resolving issues through an informal process does not suspend or postpone these timeframes.

The intent of this section is to describe the options available to behavioral health providers to resolve issues and other events related to a decision of the RBHA or ADHS/DBHS. The section is organized to delineate the process for filing a claim dispute:

For behavioral health providers disputing a decision of a RBHA;

For behavioral health providers disputing a decision of ADHS/DBHS; and

The process for requesting an administrative hearing in the event a behavioral health provider does not agree with the claim dispute decision of a RBHA or ADHS/DBHS.

II. REFERENCES



The following ADHS/DBHS site also serves as a resource for this content area:

[A.R.S. § 36-2903.01.B.4](#)

[A.R.S. § 36-3413](#)

[A.R.S. Title 41, Chapter 6, Article 10](#)

[9 A.A.C. 34, Article 4](#)

[2 A.A.C. 19, Article 1](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contracts](#)

[ADHS/T/RBHA IGAs](#)

[AHCCCS Contractor Operations Manual, Section 206](#)

III. STANDARDS

ADHS/DBHS and CSP must ensure that when a claim for payment is denied in whole or in part, or a decision is made to impose a sanction, the affected provider is advised in writing of the right to file a claim dispute.

The entire provider claim dispute process is outlined on [PM Attachment 5.6.2](#).

IV. PROCEDURES

A. Prior to filing an initial claim dispute

All behavioral health providers are encouraged to seek informal resolution of a concern by first contacting the appropriate entity responsible for the decision. For concerns regarding claims, it is important for providers to understand why the claim was denied before initiating a claim dispute. Denied claims may be the result of filing errors or missing supporting documentation, such as an explanation of benefits (EOB) or an invoice. Resubmitting claims with the requested information or corrections can result in resolution of the issue and full payment of the claim. [PM Attachment 5.6.1](#) identifies contact persons at CSP and ADHS/DBHS that can assist with the informal resolution of a decision.

B. Process for initiating a claim dispute to CSP

If an issue is unable to be resolved informally, behavioral health providers may dispute the decision by filing a written claim dispute. For all provider claim disputes related to decisions of a RBHA, the provider must file the claim dispute with CSP. See [PM Attachment 5.6.1](#) for information regarding where to submit a claim dispute.

What does a written claim dispute include?

It is important for providers to ensure the claim dispute contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.



The claim dispute submitted must contain:

- A statement of the factual and legal basis for the dispute; and
- A statement of the relief requested.

What are the timeframes for initiating a claim dispute?

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the date of notice advising that a sanction will be imposed, or
- For a denial of a claim for payment, or, nonpayment of a claim, within:
 - 12 months of the date of delivery of the service; or
 - 12 months after the date of eligibility posting; or
 - Within 60 days after the denial of a timely claim submission, whichever is later.

How is time computed?

A written claim dispute is considered filed when it is received by CSP established by a date stamp or other record of the receipt. Behavioral health providers must use the following methodology in computing any period of time described in this section: Computation of time for calendar day begins the day after the act, event or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

What happens after a provider files a claim dispute with CSP?

Within five days of receiving the claim dispute, CSP will notify the provider in writing that:

- The claim dispute has been received;
- The claim dispute will be reviewed; and
- A decision will be issued within 30 days of receipt of the claim dispute unless an extension has been agreed upon.

It is possible that CSP will determine that it is not the appropriate entity to process the claim dispute. This can happen when CSP determines that it is not responsible for the denial or non-payment of the disputed claim or imposition of a sanction.



If CSP determines that it is not responsible for the decision, the claim dispute and all documentation will be sent immediately to the appropriate entity as well as a copy of the transmittal and all documentation to the provider that initiated the claim dispute.

How long does CSP have to make a decision?

A decision on the claim dispute will be made by CSP within 30 days of receipt of the claim dispute, unless CSP and the provider both agree, in writing, to a longer period. To request an extension of the 30-day timeframe, the provider must submit to CSP, prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe that does not unreasonably postpone final resolution of the matter. A representative of CSP may also request an extension. In either case, the provider and CSP must agree to the extension in writing.

How will a provider be informed of the claim dispute decision?

A written decision, referred to as a Notice of Decision, will be hand delivered or sent by certified mail to the provider by CSP. The decision letter will include a statement of the nature of the claim dispute and the issues involved and will:

- Approve or deny the claim for payment; or
- Affirm or reverse the denial, in whole or in part; or
- Affirm or reverse the sanction, in whole or in part; and
- Include the date of the decision; and
- Include a statement of the reasons for the decision and the statutes, rules and policies involved; and
- Include a statement that a provider dissatisfied with the decision may request an administrative hearing by filing a request with the ADHS/DBHS Office of Grievance and Appeals within 30 days of receipt of the decision. Included with the statement is a description of the provider's right to request an informal settlement conference.

C. Administrative hearing process for claim dispute decisions made by CSP:

If the provider is dissatisfied with CSP Notice of Decision, the provider may request an administrative hearing by filing, in writing, a request with the ADHS/DBHS Office of Grievance and Appeals. See [PM Attachment 5.6.1](#) for contact information and where to submit a request for an administrative hearing.

What are the timeframes for requesting an administrative hearing?



The provider's request for a hearing must be filed in writing and received by ADHS/DBHS within 30 calendar days of the date of receipt of CSP claim dispute decision. A written request for hearing is considered filed when received by ADHS/DBHS Office of Grievance and Appeals established by a date stamp or other record of receipt.

What does a request for administrative hearing include?

In filing the request for an administrative hearing to ADHS/DBHS, the provider must include:

- Provider name, address and the ADHS/DBHS docket number;
- The issue to be determined at the administrative hearing; and
- The factual and legal basis for the request for administrative hearing.

What happens after a provider files a request for administrative hearing with ADHS/DBHS?

Upon receipt of a request for hearing, the ADHS/DBHS Office of Grievance and Appeals will schedule an administrative hearing at the State Office of Administrative Hearings. Statute requires an administrative law judge to conduct the administrative hearing within 60 days after the request is filed and issue a written recommended decision to the ADHS Director within 20 days after the hearing is completed. The ADHS Director will issue a final decision within 30 days after receiving the administrative law judge's recommended decision.

What options exist following the ADHS Director's decision?

The provider may appeal a final administrative decision as follows:

- For claim disputes involving Title XIX and XXI services, the provider has the option of filing a written notice of appeal of the ADHS Director's final decision to the Arizona Health Care Cost Containment System. This appeal must be filed with the ADHS Office of Administrative Counsel within 30 calendar days after service of the ADHS Director's decision;
- File a motion for rehearing with the ADHS Director within 30 days after service of the ADHS Director's decision; or
- For final administrative decisions, file a petition for judicial review with the Arizona Superior Court within 35 days after service of the ADHS Director's decision.

D. Process for initiating a claim dispute to ADHS/DBHS

If an issue is unable to be resolved informally, behavioral health providers may file a written claim dispute. For all claim disputes related to decisions of ADHS/DBHS, the



provider must file the claim dispute with ADHS/DBHS. See [PM Attachment 5.6.1](#) for information regarding where to submit a claim dispute.

What does a claim dispute include?

It is important for providers to ensure the claim dispute contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

The claim dispute submitted must contain:

- A statement of the factual and legal basis for the claim dispute; and

A statement of the relief requested.

What are the timeframes for initiating a claim dispute?

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the notice advising that a sanction will be imposed, or
- For a denial of a claim for payment (in whole or in part), or, nonpayment of a claim, within:
 - 12 months of the date of delivery of the service; or
 - 12 months after the date of eligibility posting; or
 - Within 60 days after the denial of a timely claim submission, whichever is later.

How is time computed?

A written claim dispute is considered filed when it is received by the ADHS/DBHS established by a date stamp or other record of receipt. Behavioral health providers must use the following methodology in computing any period of time described in this section:

- Computation of time for calendar day begins the day after the act, event or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

What happens after a provider files a claim dispute with ADHS/DBHS?

Within five days of receiving the claim dispute, ADHS/DBHS will notify the provider in writing that:

- The claim dispute has been received;
- The claim dispute will be reviewed; and



- A decision will be issued within 30 days of receipt of the claim dispute.

It is possible that ADHS/DBHS will determine that it is not the appropriate entity to process the claim dispute. This can happen when ADHS/DBHS determines that it is not responsible for the denial or non-payment of the disputed claim or imposition of a sanction.

If ADHS/DBHS determines that it is not responsible for the claim dispute, the claim dispute and all documentation will be sent immediately to the appropriate entity as well as a copy of the transmittal and all documentation to the provider that initiated the claim dispute.

How long does ADHS/DBHS have to make a decision?

A final decision on the claim dispute will be made by ADHS/DBHS within 30 days of receipt of the claim dispute, unless ADHS/DBHS and the provider both agree, in writing, to a longer period. To request an extension of the 30-day timeframe, the provider must submit to ADHS/DBHS, prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe that does not unreasonably postpone final resolution of the matter. A representative of ADHS/DBHS may also request an extension. In either case, the provider and ADHS/DBHS must agree to the extension in writing.

How will a provider be informed of the claim dispute decision?

A written final decision, referred to as a Notice of Decision, will be hand delivered or sent by certified mail to the provider by ADHS/DBHS. The final decision letter will include a statement of the nature of the claim dispute and the issues involved and will:

- Approve or deny the claim for payment; or
- Affirm or reverse the denial, in whole or in part; or
- Affirm or reverse the sanction, in whole or in part; and
- Include the date of the decision;
- Include a statement of the reasons for the decision and the statutes, rules and policies involved; and
- Include a statement that a provider dissatisfied with the decision may request an administrative hearing by filing a request with the ADHS/DBHS Office of Grievance and Appeals within 30 days of receipt of the decision. Included with the statement is a description of the provider's right to request an informal settlement conference.



E. Administrative hearing process for claim dispute decisions made by ADHS/DBHS

If the provider is dissatisfied with the ADHS/DBHS Notice of Decision, the provider may request an administrative hearing by filing, in writing, a request with the ADHS/DBHS Office of Grievance and Appeals. See [PM Attachment 5.6.1](#) for contact information and where to submit a request for an administrative hearing.

What are the timeframes for requesting an administrative hearing?

The provider's request for a hearing must be filed in writing and received by ADHS/DBHS within 30 calendar days of the date of receipt of the ADHS/DBHS Notice of Decision. A written request for hearing is considered filed when received by ADHS/DBHS Office of Grievance and Appeals established by a date stamp or other record of receipt.

What does a request for administrative hearing include?

In filing the request for an administrative hearing to ADHS/DBHS, the provider must include:

- Provider name, address and the ADHS/DBHS docket number;
- The issue to be determined at the administrative hearing; and
- The factual and legal basis for the request for administrative hearing.

What happens after a provider files a request for administrative hearing with ADHS/DBHS?

Upon receipt of a request for hearing, the ADHS/DBHS Office of Grievance and Appeals will schedule an administrative hearing at the State Office of Administrative Hearings. Statute requires an administrative law judge to conduct the administrative hearing within 60 days after the request is filed and issue a written recommended decision within 20 days after the hearing is completed. The ADHS Director will issue a final decision within 30 days after receiving the administrative law judge's recommended decision.

What options exist following the ADHS Director's decision?

The provider may appeal a final administrative decision as follows:

- For claims disputes involving Title XIX and XXI services, the provider has the option of filing a written notice of appeal of the ADHS Director's final decision to the Arizona Health Care Cost Containment System. This appeal must be filed with the ADHS Office of Administrative Counsel within 30 calendar days after service of the ADHS Director's decision;
- File a motion for rehearing with the ADHS Director within 30 days after service of the ADHS Director's decision (see reference [A.R.S. 41-1092.09](#); or



- For final administrative decisions, file a petition for judicial review with the Arizona Superior Co