

REVISION DATES: 7/1/2021 ; 10/1/18; 7/24/2018; 12/30/2015; 04/26/2013; 05/31/2012

General Information

Providers should exhaust all authorized processing procedures before filing a claim dispute with the AHCCCS Office of Administrative Legal Services (OALS). It is recommended that providers follow these guidelines before filing a claim dispute.

If the provider has not received a Remittance Advice identifying the status of the claim, the provider should utilize AHCCCS Online at <http://www.azahcccs.gov> to view the claim's status to determine whether the claim has been received and processed.

Once at the website home page, click on the icon for Plans/Providers (blue tab at top of the screen). A link on the Provider Website (AHCCCS Online) allows providers to create an account so that they can check the status of their claims.

Providers should allow 14 days following claim submission before inquiring about a claim. However, providers should inquire well before 6 months from the date of service because of the initial claim submission time frame and the time frame for filing a claim dispute.

If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim by the AHCCCS Administration may be cause for OALS to entertain a claim dispute on a pended claim provided all claim dispute deadlines are met.

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with OALS.

Time Limits for Filing a Dispute

A provider must institute any claim dispute challenging the claim denial or adjudication within 12 months from the ending date of service; the date of a member's eligibility posting; or, for a hospital inpatient claim, within 12 months from the date of discharge; or within 60 days after the date of the denial of a timely claim submission, whichever is later. The date of receipt by OALS is considered the date the claim dispute is filed.

If action is taken on a timely submitted, clean claim fewer than 60 days before the expiration of the 12 month deadline or after the 12 month deadline has passed, the provider will be allowed 60 days from the date of the adverse action to file a claim dispute. The date of the "adverse action" is the status date for the claim as printed on the Remittance Advice.

Example:

03/06/2013 Date of service
05/15/2013 Initial claim denied by AHCCCS
12/16/2013 Date of resubmission of denied claim
03/04/2014 Claim is denied by AHCCCS (adverse action date)
03/06/2014 12-month claim dispute deadline (clean claim)
05/05/2014 Special 60-day claim dispute deadline

Because the denial of the claim was less than 60 days from the 12-month deadline, the provider is given 60 days from the date of the adverse action (03/04/2014) to file a claim dispute.

Claim Dispute Process

A claim dispute must be submitted in writing. It should be mailed to:

AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P.O. Box 25520
Phoenix, AZ 85002

The claim dispute also may be hand delivered to:

AHCCCS Office of Administrative Legal Services
801 E. Jefferson Street, 4th Floor
Phoenix, AZ 85034

Providers also may submit a claim dispute via fax at (602) 253-9115.

Providers registered with AHCCCS Online also may submit a claim dispute via the AHCCCS Online Provider Portal as of August 16th, 2018. There are no changes to the claim dispute requirements when submitting online.

The claim dispute must state in detail the factual and legal basis for the claim dispute and the relief requested (e.g., payment, specific claim denial, quick pay discount). Claim disputes lacking specificity will be denied. The provider should include any documents which support the facts of the case.

Upon receipt of a claim dispute, OALS sends a letter of acknowledgment to the provider. This letter should be retained for reference.

The provider will receive a written Notice of Decision from OALS which will approve, deny, or partially approve the disputed claim.

If a provider disagrees with the Notice of Decision, the provider may request a state fair hearing. Requests for a state fair hearing must be filed in writing no later than 30 days from receipt of the Notice of Decision.

The written request must be received by OALS no later than 30 days from the date of receipt of the written Notice of Decision. If the 30th day falls on a Saturday, Sunday, or legal holiday, the claim dispute must be received no later than the next working day.

Approving a Claim Dispute

If OALS determines that the original claim denial was in error, the claim is forwarded from OALS directly to the AHCCCS Claims Unit for reprocessing. Providers should **not** resubmit the claim to AHCCCS with a copy of the written Notice of Decision from OALS.

Approving a claim dispute does not:

- Guarantee payment, or
- Constitute a waiver of all claim filing requirements and conditions.

Claims that were a part of a claim dispute approval may still not be payable for other reasons.

Claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied or an edit may fail, even though the claim dispute has been approved for other reasons.

If the provider receives an additional denial, unrelated to the initial dispute that was previously approved through OALS, the provider should contact the AHCCCS Claims Customer Service Unit. The provider must reference the previous claim dispute number and indicate that the claim was forwarded by OALS.

Hearing Process

All AHCCCS hearings are conducted by the Arizona Office of Administrative Hearings, an independent state agency. An administrative law judge from the Office of Administrative Hearings will conduct the hearing, decide the facts, apply law, and make a recommendation to the AHCCCS Director.

If a hearing is scheduled, the AHCCCS Administration will notify the provider in writing of a hearing date, time, and location.

Requests and motions concerning the case must be submitted in writing to the assigned administrative law judge. All requests and motions also must be copied to any other party and the AHCCCS Administration.

Requests to reschedule a hearing must be submitted in writing to the Arizona Office of Administrative Hearings. All requests to conduct hearings telephonically must be submitted in writing to the Office of Administrative Hearings.

Subpoenas must be submitted to the Office of Administrative Hearings for the assigned administrative law judge's approval. Subpoena forms and instructions for completing the forms are available from the Office of Administrative Hearings.

The administrative law judge's recommendation will be forwarded to the AHCCCS director. The AHCCCS Administration will issue a director's decision. A petition for a re-hearing must be submitted within 30 days of the director's decision. The director will determine whether to amend the decision or order a re-hearing.

Office of Administrative Hearings
1740 W. Adams Street
Lower Level
Phoenix, AZ 85007
Telephone: (602) 542-9826
Fax: (602) 542-9827
Website: www.azoah.com

Disputes Not Related to Claims

Disputes unrelated to claims denial (e.g., enforcement of a policy, recoupment actions, or unfavorable decision by AHCCCS) must be filed in writing and received by no later than 60 days after the date of the adverse action.

Any documents that support the facts of the case should be included. The dispute should state in detail the factual and legal basis, and the relief requested. Failure to do so may constitute cause for denial of the dispute.

If a written Notice of Decision is issued, the provider may submit a written hearing request as described earlier. Some cases may be referred directly for a hearing.

Claim Dispute Submission Suggestions

In recent years, reimbursement for medical services has become increasingly more complex. The following are a few suggestions to help you through the claim dispute process.

- If a provider files a claim dispute concerning nonpayment, but payment is made before a written Notice of Decision is made, the provider should submit a letter to withdraw the dispute.

Once the claim is paid, if the provider is dissatisfied with reimbursement, a claim dispute may then be filed within the required time frames.

- Claim disputes for members enrolled in a health plan on the date of service in dispute must be filed with the health plan.
- If a provider believes that the AHCCCS Claims Customer Service Unit provided erroneous information, the claim dispute must specify the following:
 1. The date of the call made to AHCCCS,
 2. The approximate time the call was made to AHCCCS, and
 3. The name or operator number of the AHCCCS operator who provided the information.

Note: Failure to provide the date and time of the call and the name of the AHCCCS operator may result in denial of the claim dispute.

- All claim disputes must be filed with specificity.

The request must state why the claim dispute is being filed and why the provider believes that the claim was not processed properly.

Failure to do so may constitute cause for denial of the claim dispute.

Dispute Avoidance

Prior to filing an appeal it may be possible for AHCCCS to review the claim through the reconsideration process.

If the provider receives a Remittance Advice from AHCCCS and believes that a claim was denied inappropriately or paid incorrectly, the provider can contact the Claims Customer Service Unit. The provider must provide the Claims Customer Service representative with the following:

- Provider ID number and/or Provider NPI

- Member's AHCCCS ID number
- Date(s) of service in question
- Claim Reference Number (CRN)
- Denial reason

NOTE: This process does not take the place of the claim dispute procedure outlined in this chapter nor does it extend the claim dispute filing deadlines.

For additional information on avoiding the dispute process, please refer to Chapter 26, Correcting Claim Errors, of the Fee-For-Service Provider Billing Manual.

For complete information on the replacement and reconsideration process please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual.

REVISION HISTORY

Date	Description of Changes	Page(s)
7/1/2021	Updated address for AHCCCS Claim Disputes.	2
10/1/2018	<p>“On-line” changed to “online” to correct the AHCCCS Online provider portal name.</p> <p>Providers registered with AHCCCS Online also may submit a claim dispute via the AHCCCS Online Provider Portal as of August 16th, 2018. There are no changes to the claim dispute requirements when submitting online.</p>	1 2
7/24/2018	<p>*The below updates do not represent a change in processes currently occurring.</p> <p>Clarifying language was added to the Claim Dispute Process chapter.</p> <p>Clarifying language was added to the Approving a Claim Dispute section.</p> <p>The Hearing Process section was updated</p> <p>Updated the address for the Office of Administrative Hearings</p> <p>The Claim Dispute Submission Suggestions section had clarifying language added (changed from ‘date’ to ‘The date of the call made to AHCCCS’)</p> <p>The section on Claim Dispute Process for Claims with Behavioral Health Diagnosis was removed, as ADHS/DBHS is no longer a part of the process</p> <p>Dispute Avoidance section updated with clarifying language</p> <p>Formatting</p>	2-3 3-4 4 4 5 All 5-6 All

	Changes “member” to “member” throughout.	All
12/30/2015	New format chapter	All
	Updated address for BH disputes not involving IHS or 638 providers	3
04/26/2013	Update by OALS; language/grammar corrections	All