ARIZONA TIMELY PAY & GRIEVANCE LAW

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This whitepaper summarizes the Timely Pay & Grievance law in Arizona. Please note that it is not intended to provide legal advice, or substitute for the advice of an attorney. The Arizona Medical Association (ArMA) makes every attempt to provide accurate and useful information, but some material may be outdated, and ArMA shall not be liable for any inaccuracy, error or omission, or any damage that may result. You should always seek counsel from a licensed attorney when dealing with legal matters.

In 2000, the Arizona Legislature created the Timely Pay and 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 added definitions to the law and clarified requirements for claims processing, grievance systems, and payment adjustments. The Timely Pay and Grievance law reflects legislative recognition that both timely, accurate payment to providers and prompt resolution of their grievances are essential components of a functional healthcare insurance system.

Clean Claims Adjudicated Within 30 Days

The basic provisions of the law require that a health care insurer must make a decision on whether to pay a "clean" health insurance claim, in whole or part, from a contracted or noncontracted health care provider within thirty days after the health care insurer receives the clean claim or within the time period specified by contract.[1] A clean claim is one that an insurer can process without obtaining additional information, including coordination of benefits information.[2]

Claims Needing Additional Information

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. An insurer making a reasonable effort to obtain information in order to process a claim may pend that claim in order to request the necessary information, but shall make a decision on the claim within 30 days after receiving all of the additional information.[3]

Adjudicated Claims Paid Within 30 Days; Interest

The health care insurer shall pay the approved portion of any claim within 30-days or within the time period specified in the provider's contract.[4] If an insurer fails to timely pay claims, the insurer must pay interest at the legal rate, beginning on the date payment was due.[5] The legal interest rate is ten percent (10%) per annum.[6] The insurer and provider may contract in writing for a different, reasonable rate but, they may not enter into a contract that excuses the insurer from paying any interest at all.

[1] ARS § 20-3102(A) [2] ARS § 20-3101(2) [3] ARS § 20-3102(B) [4] ARS § 20-3102(B) [5] ARS § 20-3102(A) [6] ARS §44-1201

Insurer Restrictions; Reasonable Justification

The Timely Pay & Grievance law restricts health care insurers from delaying payment on clean claims or paying less than the amount agreed to by contract, without reasonable justification.[7] Further, 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.[8] The insurer is also prohibited from requesting information that does not apply to the medical condition at issue for purposes of adjudicating a clean claim.[9]

One Year Time Limit on Adjustments

Except in cases of fraud, 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. 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.[10]

Provider Grievances

Insurers are required to establish an internal system for resolving payment disputes and other provider grievances. This is important because the Arizona Department of Insurance and Financial Institutions (AZDIFI) does not handle disputes between health care insurers and health care providers. Rather, the AZDIFI's role is to verify that an insurer's grievance system is sufficient and effective.[11]

[7] ARS § 20-3102(C) [8] ARS § 20-3102(E) [9] ARS § 20-3102(D) [10] ARS § 20-3102(H) [11] ARS § 20-3102(F)

Definition of Grievance

A provider grievance[12] is any written complaint subject to the Timely Pay & Grievance law, and submitted by a provider and received by a health care insurer, 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 (See, ARS § 20-2530 et seq.).

Moreover, the definition of "grievance" is not limited to payment disputes, or to contracted provider grievances. Insurers may have payment disputes with both contracted and non-contracted providers and will need a grievance system that accommodates and reports payment disputes regardless of the contract status of the provider. At the same time, the grievance system must accommodate grievances from both contracted and non-contracted providers about matters other than payment disputes, including, but not limited to systemic or operational problems, quality assurance problems, or network adequacy problems unrelated to the provider's contract status.[13]

[12] ARS § 20-3101(4)

[13] ARS § 20-3102(F)

Characteristics of an Internal Grievance System

As per AZDIFI guidelines, an insurer has both the opportunity and the operational ability to promptly correct its own mistakes. Insurers' systems may vary, particularly depending on their product structure and networks, but for an insurer's grievance system to be deemed effective it must include the following basic characteristics:

- Must have a written grievance policy that is available to providers upon request.
- Grievances should be "administratively simple," affording the provider a reasonable opportunity to present information and communicate with the decision maker orally or in writing as appropriate.
- 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.

Grievance Records and Reporting; Enforcement

The law requires insurers to maintain records of provider grievances on a grievance-by-grievance basis. The grievance records must include specific information, in addition to additional information the Director requires.[14] Insurers must file semi-annually with the AZDIFI a grievance report that summarizes all grievance records.[15] This report is a critical monitoring tool that provides the Department with important information about the insurer. It can serve as an indicator of, among other things, solvency problems, network inadequacies and quality assurance deficiencies. Upon review of the records, if AZDIFI finds a "significant number" of grievances have not been resolved, the Director may examine the insurer.[16]

[14] ARS § 20-3102(4) [15] ARS § 20-3102(F) [16] ARS § 20-3102(G)

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The Arizona Department of Insurance and Financial Institutions

The Providers should file original grievances with the insurer, not with the Department. However, the AZDIFI does provide grievance information resources, and a portal to submit a consumer complaint when a matter falls within their jurisdiction. This can be accessed online at **https://difi.az.gov/providers**.

Or you can contact the Department at the following address/phone:

Arizona Department of Insurance and Financial Institutions
100 N. 15th Avenue, Suite 261, Phoenix, AZ 85007-2630
Phone Insurance Division Main: (602) 364-3100;
Toll-free: (800) 325-2548

For additional information, contact ArMA here: Arizona Medical Association (azmed.org)