



**GRIEVANCE SYSTEM REPORTING
GUIDE**

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I. PURPOSE

The AHCCCS Grievance System Reporting Guide applies to Acute Care, ALTCS/EPD, CRS, DES/CMDP (CMDP), DES/DDD (DDD), ADHS/DBHS, and Medicare Advantage (MA) D-SNP Contractors. The purpose of the Guide is to provide instructions to Contractors on how to complete the Grievance System Report for submission to and review by the Division of Health Care Management (DHCM), as required by contract.

ADHS/DBHS reports data received from the Tribal and Regional Behavioral Health Authorities (T/RBHAs).

DES/DDD reports Long Term Care data and data received from its Acute Care subcontractors.

II. DEFINITIONS

ACTION – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner as set forth in contract; the failure of a Contractor to act within the timeframes specified in contract; and for members residing in a rural area with only one Contractor, the denial of a member’s right to obtain services outside the Contractor’s network.

APPEAL – A request for review of an action.

AUTHORIZATION REQUEST (STANDARD) – A request for the authorization of services for which a Contractor must provide a decision as expeditiously as the member’s health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member’s best interest. (42 CFR 438.210)

AUTHORIZATION REQUEST (EXPEDITED) – A request for the authorization of services which the provider or a Contractor determines that using the standard timeframe could seriously jeopardize the member’s life or health or the ability to attain, maintain or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires but no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member’s best interest. (42 CFR 438.210)

CLAIM DISPUTE – As used in this guide, a claim dispute is a dispute involving payment of a claim or-a denial of a claim. For the purposes of recording the accurate number of disputes, each individual claim addressed in a filing equates to one dispute e.g. a filing where the provider included 10 claims in a single submission would be counted as 10 individual Claim Disputes.

DATE OF DECISION (DOD) – For Authorization Requests the date that the Contractor makes and communicates the decision to the member and/or his/her designated representative.

DATE OF PROCESSING (DOP) – Date that the appeal, claim or claim dispute decision is communicated by the Contractor.

DATE OF RECEIPT (DOR) – Date that the authorization request, appeal, claim or claim dispute is received by the Contractor.

DAY – Calendar day unless otherwise specified.

EXPEDITED AUTHORIZATION REQUEST - A request for services in which either the requesting provider indicates or the Contractor determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In these circumstances, the authorization decision must be expedited and must be made within three working days from the date of receipt of the service request.

GRIEVANCE – An expression of dissatisfaction about a matter other than an action as defined in Arizona Administration Code Title 9, Chapter 34 (9 A.A.C. 34). Possible subjects for grievances include, but are not limited to: the quality of care or services provided; aspects of interpersonal relationships; rudeness of a provider or employee or failure to respect the member's rights.

INCORRECT HANDLING – Error in the Contractor's claims process that led to a denial, payment, or partial denial of a claim that resulted in a claim dispute request. (Examples include, but are not limited to: provider contract loading delay; provider contract loading error; paid at the wrong rate; fee schedule not updated; improper or incorrect denial reason; EOB was overlooked, secondary review as defined below, etc.).

INDEPENDENT REVIEW ENTITY (IRE) – An independent entity contracted by the Centers for Medicare and Medicaid Services (CMS) to review denials of coverage determinations.

MEMBER – A person who is eligible for AHCCCS and who is enrolled with a Contractor, also known as an enrollee.

NOTICE OF ACTION – The written notice to the member regarding an action by the Contractor. The contents of a Notice of Action are strictly defined in Contract and ACOM Policy 414.

NOTICE OF APPEAL RESOLUTION - The written notice to the member and/or his/her designated representative regarding the final determination of an appealed action. The contents of a Notice of Appeal Resolution are strictly defined in Contract, Rule, and Policy.

NOTICE OF DECISION – The written notice sent to the provider regarding the final determination of a disputed claim payment or claim denial. The contents of a Notice of Decision are strictly defined in Contract, Rule, and Policy.

OVERTURNED – The original decision of the Contractor is determined incorrect or incomplete and is reversed. This category is further divided into those disputes that are reversed due to Contractor error in processing (overturned due to incorrect handling and those that are reversed due to additional information being submitted by the member or provider which provides the grounds for the reversal (overturned due to additional information submitted).

PARTIALLY OVERTURNED – The original decision of the Contractor was reversed, but the outcome is not entirely in the member and/or provider’s favor. This category is further divided into those disputes that are reversed due to Contractor error in processing (partially overturned due to incorrect handling and those that are reversed due to additional information being submitted by the member or provider which provide the grounds for the reversal (partially overturned due to additional information submitted).

PRE-SERVICE MEMBER APPEALS – An appeal made by the member before a provider claims/payment dispute is made.

SECONDARY REVIEW – An evaluation conducted by another medical professional to confirm the accuracy of an initial determination.

STATE FAIR HEARING - An administrative hearing under A.R.S. Title 41, Chapter 6, Article 10.

TURN AROUND TIME (TAT) – The time from the date of receipt to the date of decision.

UPHELD – The original determination of the Contractor is maintained.

III. GRIEVANCE SYSTEM REPORT

The Contractor must adhere to all requirements specified in contract (Attachment F1, Enrollee Grievance System Standards, F2, Provider Claim Dispute Standards, and the Grievance System paragraph) and ACOM Policy 414, related to member notification and timeframes for submission of appeals and requests for hearing.

The Contractor is required to utilize the Grievance System Reporting Template, which includes Attachments A through G of this Guide, for submittal of the Grievance System Report.

The Contractor must use one Grievance Report Template to report a 12-month period of reporting data. The Contractor must identify each submitted report by entering the name of the Contractor and the reporting period. Additionally, the Contractor must submit a corrected report if data in a previous report is changed.

The Grievance System Report shall be submitted via the AHCCCS FTP server with an electronic mail notification submitted to the designated Operations and Compliance Officer and is due as specified below. All questions regarding the reporting requirements must be directed to the designated Operations and Compliance Officer.

The Grievance System Report includes:

1. Cover Letter (Cover Letter Template)
2. Claim Dispute Report (Attachment A)
3. Authorization Request and Appeal Report (Attachment B)
4. Member Grievance Reports (Attachments C, D, E, and F)
5. Member Medicare D-SNP Appeals Report (Attachment G)

COVER LETTER

The Contractor must generate and submit the Grievance System Report with an accompanying cover letter (email is not an accepted form of cover letter) that summarizes the data, explains significant trending in either direction (positive or negative), and explains any interventions implemented as a result of identified issues for each Attachment. The cover letter must be submitted using the [Cover Letter Template](#) and must **also** include:

1. An explanation of claim disputes that have not been resolved within 30 days as identified in Attachment A;
2. A narrative that identifies the reason(s) for the Contractor initiated settlement(s) identified in Attachment A, Section C. Request for Hearing Summary;
3. A definition of new categories identified in Attachment A, Section D. Categorical Trending Analysis;
4. An explanation of member appeals that have not been resolved within 30 days as identified in Attachment B;
5. A narrative that identifies the reason(s) for the Contractor initiated settlement(s) identified in Attachment B, Section H. Expedited Appeals;
6. An explanation of delayed resolutions (those more than 90 days from receipt) as identified in Attachments C, D, E, and F, Member Grievance Reports; and
7. Service level detail on the appeals that were upheld and overturned, including a description of the action which is appealed as identified in Attachment G, MA-D-SNP Member Pre-Service Appeals Report.

ATTACHMENTS A THROUGH F:

Acute, ALTCS/EPD, CRS, and CMDP: Due monthly - the first day of the 2nd month following the month being reported for all Contractors except DES/DDD and ADHS/DBHS.

DDD: Due monthly - the tenth day of the 2nd Month following the month being reported.

ADHS/DBHS: Due monthly - the first day of the 3rd month following the month being reported.

ATTACHMENT G:

MA D-SNP Health Plans: Due quarterly - the first day of the 2nd month following the quarter being reported.

IV. GRIEVANCE SYSTEM REPORTING TEMPLATE

INSTRUCTIONS

Instructions for completing the Template Attachments are provided below.

ATTACHMENT A: CLAIM DISPUTE REPORT

SECTION A. CLAIM DISPUTES SUMMARY

The numbers in Section A must be reported by age of the Claim Dispute as determined by Date of Receipt (DOR) through Date of Processing (DOP); and also by total number in the category.

- A1. The total number of Claim Disputes that remained open from the previous reporting period (reported in Row A4) must be carried over to this report. The total must equal the sum of the 3 categories below.
 - I. Ending Inventory from Previous Month \leq 30 days
 - II. Ending Inventory from Previous Month $>$ 30 days and \leq 45 days
 - III. Ending Inventory from Previous Month $>$ 45 days
- A2. Total number of Claim Disputes logged as received during the reporting period.
- A3. Total number of Claim Disputes closed during the reporting period.
- A4. The total number of Claim Disputes remaining from the previous reporting period added to those received during the current period and subtracting those closed during the reporting period ($A1 + A2 - A3 = A4$). The total must equal the sum of the 3 categories below.
 - I. Current Inventory at End of Month \leq 30 days
 - II. Current Inventory at End of Month $>$ 30 days and \leq 45 days
 - III. Current Inventory at End of Month $>$ 45 days

SECTION B. CLAIM DISPUTE DECISIONS

The numbers in Section B must be reported as a total number of disputes that can be assigned to the category.

- B1. The total number of upheld Claim Disputes upheld (excluding untimely dispute filings) during the reporting period including those that were opened in previous periods.
- B2. The total number of upheld Claim Disputes received by the Contractor later than 12 months after the date of service, later than 12 months after the date that eligibility is posted or later than 60 days after the date of the denial of a timely claim submission.

- B3. The total number of overturned Claim Disputes during the reporting period; including those received in previous periods.
 - I. Overturned due to a finding of incorrect handling that with all available information at the time of first review, the claim was inappropriately denied based on medical necessity or administrative criteria.
 - II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

- B4. The total number of partially overturned Claim Disputes during the reporting period, including those received in previous periods.
 - I. Partially overturned due to an incorrect handling finding that with all available information at the time of first review, the claim was inappropriately denied based on medical necessity or administrative criteria.
 - II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

- B5. The total number of Claim Disputes requiring an extension.

- B6. The total number of Claims forwarded for reprocessing as the result of an overturned, or partially overturned, Claim Dispute.

SECTION C. REQUEST FOR HEARING SUMMARY

The numbers in Section C must be reported by the total number of State Fair Hearing Requests meeting the categorical criteria. The Contractor must report all State Fair Hearing activity occurring during the reporting period, regardless of when the original dispute was received.

- C1. The total number of Requests for State Fair Hearing (RFH) received during the reporting period.

- C2. The number of RFH forwarded to the AHCCCS Office of Administrative Legal Services (OALS) or other regulatory agency within five business days of receipt by the Contractor.

- C3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) or other regulatory agency more than five business days from the date of Contractor receipt.

- C4. The total number of cancelled (withdrawn or vacated) RFH.
 - I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor

- II. Percentage of RFH cancelled due to Contractor initiated settlement (Formula built in)
 - III. Provide a narrative in the cover letter that identifies the reason(s) for the Contractor initiated settlement(s)
- C5. The total number of Director’s Decisions received during the reporting period that found in favor of the Provider, either in whole or in part.
- C6. The total number of Director’s Decisions received during the reporting period that found in favor of the Contractor’s determination (; excluding Decisions reported in C4).

SECTION D. CATEGORICAL TRENDING ANALYSIS

The numbers in Section D must be reported as both a total number per category and as a percentage of the total number of disputes received for the reporting period (A2).

Available categories (not exclusive of new categories as needed and defined in the cover letter) include:

COD (Coding Dispute) – Disputes of a coding nature such as claims containing incorrect HCPCS; CPT; ICD-9 codes; Revenue Codes and/or modifiers.

DSI (Data Source Issues) – Disputes that are in reference to incorrect recognition of contract; provider registration or member enrollment status.

NPA (No Prior Authorization) – Instances where a claim was denied for requiring prior authorization.

NAM (No Authorization Match) – Instances where a claim was denied because the billed charges or length of stay do not correlate to the Contractor’s prior authorization records.

CPE (Claim Processing Error) – Disputes that challenge the correctness of information presented on the Remittance Advice (Examples include: processed to incorrect provider, incorrect member, incorrect procedure code, etc.).

TOC (Timeliness of Claim) – Claims that are resubmitted as a challenge to the finding of timeliness of the original claim submission.

TOP (Timeliness of Payment) – Disputes that are filed on claims that have not been adjudicated.

NPC (Not Paid Correctly) – Dispute filed due to a difference in the expected reimbursement and the Contractor’s remittance.

- D1 - D5. List the top five categories of dispute by volume using the listed or separately noted acronym or abbreviation.

SECTION E. PROVIDER TRENDING ANALYSIS

- E1 - E5. List the top five providers including: the total number of disputes received from the provider in the reporting period; the percentage of the number of disputes received from the provider of the total volume of disputes received for the reporting period; the AHCCCS Provider Identification Number, and the largest dispute category received from the provider during the reporting period. For purposes of this reporting a physician's group is considered one provider.
- I. AHCCCS Provider Identification Number
 - II. Total number of disputes received from the top five providers,
 - III. The percentage of the number of disputes received from the provider divided by the total number of disputes received for the reporting period (Formula built in)
 - IV. The dispute category with the largest number of disputes received from the provider in the reporting period

[END OF ATTACHMENT A]

ATTACHMENT B: PRIOR AUTHORIZATION REQUEST AND APPEAL REPORT

SECTION A. SUMMARY OF AUTHORIZATION REQUESTS

- A1. The total number of authorization requests received during the reporting period to contain all categories of prior authorization requests regardless of urgency or assigned priority (e.g. Standard, Expedited, Extended, etc.). ALTCS/EPD and DDD Contractors must recognize one Authorization Request for each Case Manager Assessment that occurs during the reporting period. This is inclusive of in-home, alternative residential setting and nursing facility member assessments.
- A2. The number of authorization requests that were not approved as requested during the reporting period (denials, suspensions, reductions, terminations). Further subdivided into the following categories (refer to ACOM 414 for more information regarding the categories):
- I. Excluded Benefit/Benefit Exhausted (make corresponding change in heading to form)
 - II. Percentage of total actions (Formula built in)
 - III. Not Medically Necessary
 - IV. Percentage of total actions (Formula built in)
 - V. Out of Network Provider
 - VI. Percentage of total actions (Formula built in)
 - VII. Not Enough Information to Render a Decision within the legal timeframe
 - VIII. Percentage of total actions (Formula built in)
 - IX. System/Program Issues, Including Coverage by Another Entity (ADHS/DBHS, CRS, TPL)
 - X. Percentage of total actions (Formula built in)
- A3. The percentage of authorization requests that resulted in an action: $A2 \div A1 \times 100$.

SECTION B. TYPE OF REQUEST

Section B contains a breakdown of the categories summarized in section A. The data in this section must be reported by the Total Number of Authorization Requests received during the reporting period, the Total Number of Authorization Requests Completed within Timeliness Standard and the Percentage of Authorization Requests Completed Timely (as calculated by dividing the timely completed requests by the total number of completed requests within the category).

- B1. The number of standard authorizations as defined under the guidelines of this reporting guide.
- B2. The number of standard authorization requests that were extended by 14 days due to member request or Contractor determination of necessity.

- B3. The number of expedited authorization requests as defined under the guidelines of this reporting guide.
- B4. The number of expedited authorization requests that were extended by 14 days due to member request or Contractor determination of necessity.
- B5. The number of expedited authorization requests that were determined not to require expedited review based on medical necessity and were, therefore, handled under the standard process guidelines.

SECTION C. AND D. STANDARD APPEALS

This section contains information regarding Standard appeals of a Contractor's action as defined in this guide.

The data in Section C is reported by age of the standard appeal as determined by subtracting DOR from the last day of the reporting period and the total number of appeals that meet the criteria for standard appeals as defined in this guide.

- C1. The number of standard appeals remaining open on the first day of the reporting period, as reported in line C5 of the previous period.
- C2. The number of standard appeals received during the reporting period.
- C3. The total number of standard appeals closed during the reporting period.
- C4. The number of standard appeals closed during the reporting period and that were completed within 30 days.
- C5. The number of standard appeals remaining open on the last day of the reporting period.
 - I. Current Inventory as End of reporting period \leq 30 days
 - II. Current Inventory as End of reporting period \leq 45 days
 - III. Current Inventory as End of reporting period $>$ 45 days

The data in Section D is reported as a total count of appeals closed during the reporting period that fall into each category.

- D1. The total number of upheld standard appeals.
- D2. The total number of standard appeals received by the Contractor later than 60 days from the date of the Notice of Action.

- D3. The total number of standard appeals overturned due to:
 - I. A secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
 - II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

- D4. The total number of standard appeals partially overturned due to:
 - I. A secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
 - II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

- D5. The total number of standard appeals requiring 14 day extensions to the thirty (30) day review period.

Section E. Requests for Hearing

The data in Section E is to be reported as a total count of Member Requested State Fair Hearing (RFH) files that meet the criteria listed below by category.

- E1. The total number of RFH files received during the reporting period.

- E2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) (or appropriate regulatory agency) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five days for standard or same-day for expedited hearing requests).

- E3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) (or appropriate regulatory agency) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five days for standard or same-day for expedited hearing requests).

- E4. The total number of cancelled (withdrawn or vacated) RFH.
 - I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor

- E5. The total number of Director's Decisions received during the reporting period that found in favor of the Member either in whole or in part.

- E6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in E4).

SECTION F., G. AND H. EXPEDITED APPEALS

This section contains information regarding requests for expedited review of an appeal of a Contractor's action as defined in this guide.

The data in Section F is reported by age of the appeal as determined by subtracting DOR from the last day of the reporting period and the total number of appeals that meet the criteria for expedited appeals as defined in this guide.

- F1. The number of expedited appeals that remained open on the first day of the current reporting period, as reported in line F5 of the previous period.
I. Ending Inventory from Previous Month > 3 days
- F2. The number of expedited appeals that were received during the reporting period.
- F3. The number of expedited appeals that were closed during the reporting period.
- F4. The number of expedited appeals closed during the reporting period that were completed within three days.
- F5. The number of expedited appeals that remained open on the last day of the reporting period.
I. Current Inventory as of End of Month > 3 days

The data in Section G is reported as a total count of appeals closed during the reporting period that fall into each category.

- G1. The total number of upheld expedited appeals.
- G2. The total number of expedited appeals received by the Contractor later than 60 days from the date of the Notice of Action.
- G3. The total number of expedited appeals overturned due to:
I. A secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

- G4. The total number of expedited appeals partially overturned due to:
 - I. A secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
 - II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.
- G5. The total number of expedited appeals requiring 14 day extensions to the three day review period that were requested and/or granted by either party to the appeal.
- G6. The total number of expedited appeal requests that did not meet the criteria for expedited review based on medical necessity and were, therefore, handled under the standard appeal process.

The data in Section H is to be reported as a total count of Expedited Member State Fair Hearing (RFH) files that meet the criteria listed below by category.

- H1. The total number of RFH files received during the reporting period.
- H2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) (or appropriate regulatory agency) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five days for standard or same-day for expedited hearing requests).
- H3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) (or appropriate regulatory agency) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five days for standard or same-day for expedited hearing requests).
- H4. The total number of cancelled (withdrawn or vacated) RFH.
 - I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor
 - II. Percentage of RFH cancelled due to Contractor initiated settlement (Formula built in)
 - III. Provide a narrative in the cover letter that identifies the reason(s) for the Contractor initiated settlement(s)
- H5. The total number of Director's Decisions received during the reporting period that found in favor of the member either in whole or in part (sustained or partially sustained).
- H6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in H4).

[END OF ATTACHMENT B]

ATTACHMENTS C, D, E, AND F: MEMBER GRIEVANCE REPORTS

1. A separate worksheet must be submitted for each of the five grievance categories.
 - Transportation
 - Medical Service
 - Contractor Service
 - Access to Care
2. The Contractor will remain ultimately responsible for adhering to the reporting requirements contained within this guideline for any grievance process, or portion of the grievance process, that has been delegated to a subcontractor through an approved arrangement.
3. All data reported on the spreadsheet must be as listed below:
 - A. Total Received: The total number of grievances related to each sub-classification during the month beginning on the first calendar day and ending on the last day of the reporting period.
 - B. Total Resolved: The total number of grievances that were closed through verbal or written methods based on research and response during the month beginning on the first calendar day and ending on the last day of the reporting period.
 - C. First Contact Resolution: Total number of grievances resolved at the time of receipt.
 - D. 1-10 Days: Total number of grievances resolved within 10 days of receipt.
 - E. 11-30 Days: The total number of grievances resolved in more than 10 days, but less than 31 days.
 - F. 31-60 Days: The total number of grievances resolved in more than 30 days, but less than 61 days.
 - G. 61-90 Days: The total number of grievances that were either resolved more than 60 days after receipt but in less than 91 days. (Subtracting the totals from each of the timeframe columns from the Total Resolved column will leave the reviewer with those grievances that were resolved more than one quarter from receipt). The Contractor must address any delayed resolutions in the cover letter. Contractor non-compliance with Member timely resolution of grievances may result in corrective action and escalation as defined in the Sanction paragraph of the applicable contract.
 - H. Average Time to Resolve (ATR): Sum of days to resolve each case individually divided by Column B. For each category, if *Column B. Total Resolved* equals '0', enter 'N/A' in *Column H, Average Time to Resolve (ATR)*.
 - I. Previous Month's ATR: Column H from report submitted for previous month.

- J. Current Month from Previous Year ATR: Column H from report submitted for the coinciding month in the previous calendar year.
- K. The number of grievances from each grievance category that was referred to the Contractor's quality management department for further research.
- L. (ROW) Summary Totals of each column: For columns A-G and K, Row L is the sum of the grievances reported in these columns. For Columns H, I, and J, Row L is the average of all ATRs for the grievances reported in these columns

ATTACHMENT C. TRANSPORTATION

Complaints made by a member/advocate related to the provision of non-emergent transportation services; which can either be related to timeliness or service level.

Sub-categories:

1. Missed appointment (includes dialysis, surgery, provider, etc.)
2. Late arrival for appointment (dialysis, surgery etc.)
3. Pick up too early
4. Wrong vehicle type sent
5. Unsafe driving
6. Vehicle unsafe (balding tires, over-heating, flat tire)
7. General complaint about driver (rude, poor hygiene, vehicle dirty, etc.)
8. General complaint about vendor, customer service representative (rude, etc.)
9. Cultural insensitivity/barriers
10. Benefit Concerns
11. Other (must provide an explanation in attachment)

ATTACHMENT D. MEDICAL SERVICE PROVISION

Complaints made by a member/advocate related to the service received from a provider, doctor, pharmacy, or facility; which include behavioral and physical complaints. These do not include Quality of Care concerns that are reviewed through the quality and peer review processes or Access to Care complaints as reported in Attachment F.

ATTACHMENT E. CONTRACTOR SERVICE

Any complaints made by a member/advocate relating to the Contractor's administrative processes or the behavior of Contractor staff.

ATTACHMENT F. ACCESS TO CARE

Access to Care complaints are only those complaints received from a member/advocate relating to appointment availability, including, but not limited to: the inability to obtain an appointment, the length of time between a request for appointment and fulfillment, or lack of available providers (PCP, specialist, pharmacy, dentist, etc.).

[END OF ATTACHMENTS C-F]

ATTACHMENT G: MEDICARE ADVANTAGE D-SNP MEMBER PRE-SERVICE APPEALS REPORT

Attachment G will be used for informational purposes only. AHCCCS will not be using this information for oversight and monitoring.

The MA D-SNP Health Plan is required to provide AHCCCS with Appeals reports. The summary report is to include data on Part C and D pre-service member appeals that were received, the outcome of those appeals, and a summary of Independent Review Entity (IRE) decisions that were received during the reporting period. Pre-service appeals are those made by a member/advocate related to denied requests for authorization of a medication, durable medical equipment, out of network provider, surgery, non-covered benefit or other service. The MA D-SNP Health Plan must also provide service level detail (e.g. motorized wheelchair with special hinges vs. DME) on the appeals that were upheld and overturned, including a description of the action which is appealed.

For Attachment G, MA D-SNP Member Pre-Service Appeals Report the categories below are defined as follows:

A. PART D DRUGS

Medicare Part D (prescription drug coverage) is a Federal program to subsidize the costs of prescription drugs for Medicare beneficiaries. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

B. PART B MEDICATIONS

Medicare Part B (medical insurance coverage) helps pay for physician services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

C. DURABLE MEDICAL EQUIPMENT (DME)

An item or appliance that is not an orthotic or prosthetic and that is designed for a medical purpose is generally not useful to a person in the absence of an illness or injury, can withstand repeated use, and is generally reusable by others.

D. OUT OF NETWORK PROVIDER

An out-of-network provider is one not contracted with the Contractor.

E. SURGERY

The practice of treating diseases, injuries, or deformities by manual or operative procedures.

F. NON-COVERED BENEFIT

Medical services that are excluded by the Contractor.

G. OTHER

Appeals for any service not included in A-F (must provide an explanation in the attachment).

The Contractor must also group the grievances by sub-category:

Subcategories:

1. Total Number of MA D-SNP Appeals received in the reporting period
2. Total Number of MA D-SNP Appeals Overturned in the reporting period**
3. Total Number of MA D-SNP Appeals Upheld in the reporting period**
4. Total Number of MA D-SNP IRE Decisions Received in the reporting Period
5. Total Number of MA D-SNP IRE Decisions Overturned in the reporting period**
6. Total Number of MA D-SNP IRE Decisions Upheld in the reporting period**

***The Contractor must provide in the cover letter, service level detail on the appeals that were upheld and overturned, including a description of the action which is appealed.*

[END OF ATTACHMENT G]

V. REFERENCES

- A.A.C. R9-34 Article 2
- A.A.C. R9-34 Article 4
- ACOM Policy 414
- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DES/CMPD Contract, Section D
- DES/DDD Contract, Section D
- Medicare Advantage D-SNP Health Plan Agreement

ATTACHMENTS A - G

**SEE THE AHCCCS GRIEVANCE SYSTEM REPORTING GUIDE WEBPAGE
FOR ATTACHMENTS A THROUGH G OF THIS GUIDE**

COVER LETTER TEMPLATE

**SEE THE AHCCCS GRIEVANCE SYSTEM REPORTING GUIDE WEBPAGE
FOR THE COVER LETTER TEMPLATE**