AHCCCS
Arizona Health Care Cost Containment System

GRIEVANCE AND APPEAL SYSTEM REPORTING GUIDE

Effective: October 1, 2022

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I. Purpose

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

DES/DDD reports Long Term Care data and data received from its Subcontracted Health Plans.

II. Definitions

For purposes of this Guide:

Computation of Time in Calendar Days	Computation of time is in calendar days begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing, 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 (Saturday or Sunday) or a legal holiday. The first day of the "count" always begins on the day after the event.
Standard Authorization Request	A request for a service that is not a medication, and which does not meet the definition of an expedited service authorization request. For standard authorization decisions (those not involving medications), the Contractor shall provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 additional calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's best interest [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(1)(i)-(ii), 42 CFR 438.404(c)(3)-(4)].
Expedited Service Authorization Request	A request for a service that is not a medication 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. For expedited authorization decisions (those not involving medications), the Contractor shall provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later

	than 72 hours following the receipt of the authorization request, regardless of whether the 72 hour deadline falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's interest [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(2)(i)-(ii), 42 CFR 438.404(c)(6)].
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 grievance, service authorization request, appeal, claim or claim dispute is received by the Contractor.
Incorrect Handling	Error in the Contractor's claims process that led to a denial, partial denial or inaccurate payment 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 Medicare health plans' adverse reconsiderations of organizational determinations.
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.

Additional definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

III. Grievance and Appeal System Report

The Contractor must adhere to all requirements specified in contract (Attachment F1, Member Grievance and Appeal System Standards, F2, Provider Claim Dispute Standards, and the Grievance and Appeal 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 and Appeal System Reporting Template, which includes Attachments A through H of this Guide, for submittal of the Grievance and Appeal System Report. The Grievance and Appeal System Report shall be submitted as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

Attachments A, B1, B2, and H of the Grievance and Appeal System Report Template shall be reported using a 12-month rolling calendar period of 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, for each month that may need correction.

All questions regarding the reporting requirements must be directed to the Contractor's designated DHCM Operations Compliance Officer (OCO).

The Grievance and Appeal System Report includes:

- Cover Letter (Cover Letter Template),
- Attachment A, Claim Dispute Report,
- Attachment B1, Prior Authorization Report,
- Attachment B2, Appeal and Hearing Request Report,
- Attachment C, Member Transportation Grievance Report,
- Attachment D, Member Medical Service Provision Grievance Report,
- Attachment E, Member Contractor Service Grievance Report,
- Attachment F, Member Access to Care Grievance Report,
- Attachment G, Member Grievances Resolved during the Contract Year, and
- Attachment H, Monthly Member Grievance Tracking Rolling 12 months.

IV. Cover Letter

The Contractor must submit the Grievance and Appeal System Report with an accompanying 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 shall be submitted using the Cover Letter Template and must address the following components:

V. Grievance and Appeal System Reporting Template

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. For the purposes of recording the accurate number of disputes, each individual claim addressed in a filing equates one dispute, e.g. a filing where the provider includes ten claims in a single submission would be counted as ten individual Claim Disputes.

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 three categories below.
   I. Ending Inventory from Previous Month ≤ 30 days
   II. Ending Inventory from Previous Month > 30 days and ≤ 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, and decisions issued, during the reporting period.

A4. The total number of Claim Disputes remaining open from the previous reporting period, added to those received during the current period and subtracting disputes closed during the reporting period (A1 + A2 - A3 = A4). The total must equal the sum of the three categories below.
   I. Current Inventory at End of Month ≤ 30 days
   II. Current Inventory at End of Month > 30 days and ≤ 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 for decisions issued during the reporting period.

B1. The total number of upheld Claim Disputes (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, received 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 processed 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 processed 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 General Council (OGC), or other appropriate regulatory agency, within five business days of receipt by the Contractor.

C3. The number of RFH that were forwarded to the AHCCCS OGC, or other appropriate 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)

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. Dispute Categories - Trending Analysis

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

Available categories for completing Section D (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. Disputing Providers - Trending Analysis

E1-E5. List the top five providers including:

I. AHCCCS Provider Identification Number,
II. Total number of disputes received from the provider,
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), and
IV. The dispute category with the largest number of disputes received from the provider in the reporting period.

For purposes of this reporting a physician's group is considered one provider.

[End of Attachment A]

Attachment B1: Prior Authorization Request Report

Section A. Summary of Authorization Requests Excluding Behavioral Health and Medication Authorization Requests

The numbers in Section A must be reported as the total number of authorization requests (excluding behavioral health and medication authorization requests) received during the reporting period.

A1. The total number of authorization requests, excluding behavioral health and medication 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.) and regardless of the status of the authorization at the end of the reporting period.

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, excluding behavioral health and medication requests, that were not approved as requested and resulted in an Adverse Benefit Determination (Action), i.e. limited authorization, denials, suspensions, reductions, or terminations. This number must be reported as the total number of Actions taken during the reporting period, regardless of when the authorization request was received.
This total is further subdivided into the following categories:

I. Not a Covered Benefit or Exhausted Benefit
II. Not Medically Necessary
III. Out of Network Provider
IV. Not Enough Information to make a Decision within the legally required timeframe
V. Coverage by Another Entity

The percentage of the number of authorization request actions in each category divided by the total number of actions taken received for the reporting period (Formula built in).

A3. The percentage of authorization requests that resulted in an action (Formula built in).

Section B. Type of Authorization Requests Excluding Behavioral Health and Medication Authorization Requests

Section B contains a breakdown of the authorization requests summarized in section A. The data in this section must be reported by the Total Number of Authorization Requests, excluding behavioral health and medication requests, received during the reporting period, the Total Number of Authorization Requests Completed within Timeliness Standard (as outlined in ACOM Policy 414) and the Percentage of Authorization Requests Completed Timely (Formula built in).

B1. Section B1 contains information on Standard Authorization Requests, including:

I. The number of standard authorizations requests, as defined in this reporting guide, received in the reporting period,
II. The number of standard authorization requests completed within the timeliness standard, and

III. The percentage completed timely (Formula built in).

B2. Section B2 contains information on Standard Authorization requests requiring an extension, including:
I. The number of standard authorization requests that were extended by 14 days due to member request or Contractor determination of necessity,
II. The number of standard authorization requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

B3. Section B3 contains information on Expedited Authorization requests, including:
I. The number of expedited authorization requests, as defined in this reporting guide, received in the reporting period,
II. The number of expedited authorization requests completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

B4. Section B4 contains information on Expedited Authorization requests requiring an extension, including:
I. The number of expedited authorization requests that were extended by 14 days due to member request or Contractor determination of necessity,
II. The number of expedited authorization requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

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 during the reporting period.

Section C. Summary of Behavioral Health Authorization Requests

The numbers in Section C must be reported as the total number of behavioral health authorization requests received during the reporting period. Behavioral health authorization requests are identified based upon the service code on the authorization request, and in accordance with ACOM Policy 110, Mental Health Parity, which defines the Mental Health and Substance Use Disorder benefit. (All medication authorization requests should be reported below in Sections E and F.)

C1. The total number of behavioral health 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.) and regardless of the status of the authorization at the end of the reporting period.

C2. The number of behavioral health authorization requests that were not approved as requested and resulted in an Adverse Benefit Determination (Action), i.e. limited authorization, denials, suspensions, reductions, or terminations. This number must be reported as the total number of Actions taken during the reporting period, regardless of when the authorization request was received.
This total is further subdivided into the following categories:
I. Not a Covered Benefit or Exhausted Benefit

II. Not Medically Necessary
III. Out of Network Provider
IV. Not Enough Information to make a Decision within the legally required timeframe
V. Coverage by Another Entity

The percentage of the number of authorization request actions in each category divided by the total number of actions taken received for the reporting period (Formula built in).

C3. The percentage of authorization requests that resulted in an action (Formula built in).

Section D. Type of Behavioral Health Authorization Requests

Section D contains a breakdown of the behavioral health authorization requests summarized in section C. The data in this section must be reported by the Total Number of Behavioral Health Authorization Requests received during the reporting period, the Total Number of Behavioral Health Authorization Requests Completed within Timeliness Standard (as outlined in ACOM Policy 414) and the Percentage of Behavioral Health Authorization Requests Completed Timely (Formula built in).

D1. Section D1 contains information on Standard Behavioral Health Authorization Requests, including:
I. The number of standard authorizations requests, as defined in this reporting guide, received in the reporting period,
II. The number of standard authorization requests completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

D2. Section D2 contains information on Standard Behavioral Health Authorization requests requiring an extension, including:
I. The number of standard requests that were extended due to member request or Contractor determination of necessity,
II. The number of standard requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

D3. Section D3 contains information on Expedited Behavioral Health Authorization requests, including:
I. The number of expedited requests, as defined in this reporting guide, received in the reporting period,
II. The number of expedited requests completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

D4. Section D4 contains information on Expedited Behavioral Health Authorization requests requiring an extension, including:
I. The number of expedited authorization requests that were extended due to member request or Contractor determination of necessity,
II. The number of expedited authorization requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

D5. The number of expedited Behavioral Health authorization requests that were determined not to require expedited review based on medical necessity and were, therefore, handled under the standard process guidelines during the reporting period.

Section E. Summary of Medication Authorization Requests

The numbers in Section E must be reported as the total number of all medication authorization requests received during the reporting period.

E1. The total number of medication 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.) and regardless of the status of the authorization at the end of the reporting period.

E2. The number of medication authorization requests that were not approved as requested and resulted in an Adverse Benefit Determination (Action), i.e. limited authorization, denials, suspensions, reductions, or terminations. This number must be reported as the total number of Actions taken during the reporting period, regardless of when the authorization request was received.
This total is further subdivided into the following categories:

I. Not a Covered Benefit or Exhausted Benefit
II. Not Medically Necessary
III. Out of Network Provider
IV. Not Enough Information to make a Decision within the legally required timeframe
V. Coverage by Another Entity

The percentage of the number of medication authorization request actions in each category divided by the total number of actions taken received for the reporting period (Formula built in).

E3. The percentage of medication authorization requests that resulted in an action (Formula built in).

Section F. Types of Medication Authorization Requests

Section F contains a breakdown of the medication authorization requests summarized in section E. The data in this section must be reported by the Total Number of Medication Authorization Requests received during the reporting period, the Total Number of Medication Authorization Requests Completed within Timeliness Standard (as outlined in ACOM Policy 414) and the Percentage of Medication Authorization Requests Completed Timely (Formula built in).

E1. Section D1 contains information on Medication Authorization Requests, including:

I. The number of medication authorizations requests, as defined in this reporting guide, received in the reporting period,
II. The number of medication authorization requests completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

F2. Section F2 contains information on Medication Authorization requests requiring an extension due to member request, including:

I. The number of medication authorization requests that were extended,
II. The number of medication authorization requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

[End of Attachment B1]

Attachment B2: Appeal and Hearing Request Report

Section A. and B. Standard Appeals

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

The data in Section A is reported by age of the standard appeal as determined by subtracting the 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.

A1. The number of standard appeals remaining open on the first day of the reporting period, as reported in line A5 of the previous reporting period.

A2. The number of standard appeals received during the reporting period.

A3. The total number of standard appeals closed during the reporting period.

A4. The number of standard appeals closed during the reporting period and that were completed within 30 days.

A5. The total number of standard appeals remaining open at the end of the reporting period. The total must equal the sum of the three categories below.
   I. Current Inventory as End of reporting period ≤ 30 days
   II. Current Inventory as End of reporting period > 30 days and ≤ 45 days
   III. Current Inventory as End of reporting period > 45 days

The data in Section B is reported as a total count of standard appeals closed during the reporting period that fall into each category for appeal resolutions issued during the reporting period.

B1. The total number of upheld standard appeals.

B2. The total number of standard appeals received by the Contractor untimely, or later than 60 days from the date of the NOA.

B3. 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 processed 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.

B4. 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 processed 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.

B5. The total number of standard appeals requiring an extension.

Section C. Requests for Hearing

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

C1. The total number of RFH files received during the reporting period.

C2. The number of RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

C3. The number of RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

C4. The total number of cancelled (withdrawn or vacated) RFH.
I. Those cancelled (withdrawn or vacated) RFH due to a settlement agreement initiated by the Contractor

C5. 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.

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. and E. Expedited Appeals

This section contains information regarding requests for Expedited Appeals of a Contractor's action, as defined in this guide.

The data in Section D is reported by age of the expedited appeal as determined by subtracting the 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.

D1. The number of expedited appeals that remained open on the first day of the current reporting period, as reported in line D5 of the previous reporting period.
I. Expedited appeals from Previous Month > three days

D2. The number of expedited appeals that were received during the reporting period.

D3. The number of expedited appeals that were closed during the reporting period.

D4. The number of expedited appeals closed during the reporting period that were completed within three days.

D5. The number of expedited appeals that remained open on the last day of the reporting period.
   I. Current Inventory as of End of Month > three days

The data in Section E is reported as a total count of expedited appeals closed during the reporting period that fall into each category for appeal resolutions issued during the reporting period.

E1. The total number of upheld expedited appeals.

E2. The total number of expedited appeals received by the Contractor untimely, or later than 60 days from the date of the NOA.

E3. 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 processed 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.

E4. 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 processed 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.

E5. The total number of expedited appeals requiring an extension.

E6. 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 during the reporting period.

Section F. Request for Hearing (Expedited)

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

F1. The total number of expedited RFH files received during the reporting period.

F2. The number of expedited RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

F3. The number of expedited RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

F4. The total number of cancelled (withdrawn or vacated) expedited RFH.
   I. Those cancelled (withdrawn or vacated) RFH due to a settlement agreement initiated by the Contractor
   II. Percentage of RFH cancelled due to Contractor initiated settlement (Formula built in)

F5. 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).

F6. 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 F4).

Section G. Reason for Appeal

The numbers in Section G must be reported as a total number per category of member appeals received for the reporting period.

G1. The total number of appeals received related to the denial of authorization or limited authorization of service.

G2. The total number of appeals received related to the reduction, suspension, or termination of a previously authorized service.

G3. The total number of appeals received related to a payment denial.

G4. The total number of appeals received related to service timeliness.

G5. The total number of appeals received related to the lack of timely plan response to an appeal or grievance.

G6. The total number of appeals received related to the plan denial of a member's right to request out of network care.

G7. The total number of appeals received related to the denial of a member's request to dispute financial liability.

Section H. Service Type related to Appeal

The numbers in Section H must be reported as a total number per category of member appeals received for the reporting period.

H1. The total number of appeals received related to general inpatient services.

H2. The total number of appeals received related to general outpatient services.

H3. The total number of appeals received related to inpatient behavioral health services.

H4. The total number of appeals received related to outpatient behavioral health services.

H5. The total number of appeals received related to covered outpatient prescription drugs.

H6. The total number of appeals received related to skilled nursing facility services.

H7. The total number of appeals received related to long-term services and supports.

H8. The total number of appeals received related to dental services.

H9. The total number of appeals received related to non-emergency medical transportation.

H10. The total number of appeals received related to any other service type.

[End of Attachment B2]

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

1. A separate worksheet must be submitted for each of the following grievance categories.
    - Transportation
    - Medical Service Provision
    - 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 in columns A through J on the spreadsheet must be as listed below:

    A. Total Received: The total number of grievances received during the reporting period related to each sub-classification.

    B. Total Resolved: The total number of grievances that were resolved/closed through verbal or written methods based on research and response during the reporting period.

    C. First Contact Resolution: Total number of grievances resolved at the time of receipt during the reporting period.

    D. 1-10 Days: Total number of grievances resolved after the date of receipt, but within 10 days of receipt during the reporting period.

    E. 11-30 Days: The total number of grievances resolved in more than 10 days, but within 30 days of receipt during the reporting period.

    F. 31-60 Days: The total number of grievances resolved in more than 30 days, but within 60 days of receipt, during the reporting period.

    G. 61-90 Days: The total number of grievances that were either resolved more than 60 days after receipt but within 90 days of receipt, during the reporting period.

    H. Average Time to Resolve (ATR): Sum of days to resolve each grievance individually divided by Column B, Total Resolved.

    I. Previous Month's ATR: Column H from the report submitted for the previous month.

    J. Current Month from Previous Year ATR: Column H from the report submitted for the corresponding month in the previous calendar year.

ATTACHMENT C. TRANSPORTATION

Complaints made by a member/advocate related to the provision of non-emergent transportation services during the reporting period.

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 (CSR) (rude, etc.)
9. Cultural insensitivity/barriers
10. Benefit Concerns
11. Late pick up after appointment
12. Other (must provide a detailed explanation in the cover letter)

ATTACHMENT D. MEDICAL SERVICE PROVISION

Complaints made by a member/advocate related to the service received from a provider, doctor, pharmacy, or facility during the reporting period. These do not include Access to Care complaints as reported in Attachment F.

Sub-categories:

1. Provider customer service
2. Provider case management
3. Quality of care/service
4. Payment or billing issues
5. Suspected fraud
6. Abuse, neglect, or exploitation
7. Other categories identified by the Contractor

ATTACHMENT E. CONTRACTOR SERVICE

Complaints made by a member/advocate relating to the Contractor's administrative processes or the behavior of Contractor staff during the reporting period.

Sub-categories:

1. Contractor customer service
2. Contractor care management
3. Quality of care/service
4. Contractor communication
5. Payment or billing issues
6. Suspected fraud
7. Lack of timely response to authorization or appeal request
8. Contractor denial of request for expedited appeal
9. Other categories identified by the Contractor

ATTACHMENT F. ACCESS TO CARE

Complaints received from a member/advocate specifically relating to appointment availability during the reporting period.

Sub-categories:

1. No provider to meet need
2. Appointment Availability
3. Office/appointment wait time to be seen
4. Obtaining prescriptions
5. Prior Authorization process
6. Provider accommodation/Office accessibility
7. Other (must provide a detailed explanation in the cover letter)

[END OF ATTACHMENTS C-F]

ATTACHMENT G: MEMBER GRIEVANCES RESOLVED DURING THE CONTRACT YEAR

The Contractor will complete Attachment G to report data on member grievances received during the contract year, broken down by service type. The data populated in this tab will only be reported with the final Grievance System Report for the Contract Year.

Sub-categories:

1. General inpatient services
2. General outpatient services
3. Inpatient behavioral health services
4. Outpatient behavioral health services
5. Covered outpatient prescription drugs
6. Skilled nursing facility services
7. Long-term services and supports
8. Dental services
9. Non-emergency medical transportation
10. Any other service type

[END OF ATTACHMENT G]

ATTACHMENT H: MONTHLY MEMBER GRIEVANCE TRACKING

All Contractors will complete Attachment H to collect a month-to-month roll-up of member grievance data received. The data populated in this tab is comprised of data from the summary total of column 'A. Total Received' from Attachments C, D, E and F.

[END OF ATTACHMENT H]

COVER LETTER TEMPLATE

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

ATTACHMENTS A - H

SEE THE AHCCCS GRIEVANCE AND APPEAL SYSTEM REPORTING GUIDE WEBPAGE FOR ATTACHMENTS A THROUGH H