

**CAREFULLY READ THE INFORMATION IN THIS PACKET
KEEP IT FOR FUTURE REFERENCE
IT HAS IMPORTANT INFORMATION ABOUT
HOW TO APPEAL DECISIONS
AzCH HAS MADE ABOUT YOUR HEALTH CARE**

AzCH Health Care Appeals Process

Help in Filing a Health Care Appeal

We send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your initial request for an appeal. When your insurance coverage is renewed, we also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our Member Services number at 1-888-926-5057 or TTY 1-866-918-4450.

In the “Member Resources” section of our website, you will find forms you can use for your appeal. AzCH developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, please call our Member Services number at 1-888-926-5057 or TTY 1-866-918-4450.

How to Know When You Can Appeal

When AzCH does not authorize or approve a service or pay for a claim, we notify you of your right to appeal that decision. Your notice may come directly from us, through a treating provider, or from one of our third party partners.

Decisions You Can Appeal

You can appeal the following AzCH decisions:

1. We do not approve a service that you or your treating provider have requested.
2. We do not pay for a covered service that you have already received.
3. We deny authorization or payment for a service as **not** “medically necessary.”
4. We do not authorize a service or pay for a claim as not covered under your policy, and you believe it is covered.
5. We fail to notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

- You disagree with our decision as to the amount of “usual and customary charges.”
- You disagree with how we are coordinating benefits when you have other health insurance.

- You disagree with how we have applied your claims or services to your plan deductible.
- You disagree with the amount of coinsurance or copayments that you paid.
- You disagree with our decision to issue or not issue a policy to you.
- You are dissatisfied with any rate increases you may receive under your insurance policy.
- You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance and Financial Institution (ADIFI), Consumer Affairs Division, 100 North 15th Avenue, Suite 261, Phoenix, AZ 85007-2630.

Who Can File a Health Care Appeal?

Either you, someone you designate (including an attorney) or your treating provider can file an appeal on your behalf. In the “Member Resources” section of our website, you will find forms you can use for your appeal. AzCH developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, please call our Member Services number at 1-888-926-5057 or TTY 1-866-918-4450.

If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Health Care Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has three levels. The appeals operate in a similar fashion, except that expedited appeals process much faster because of your condition.

Expedited Appeals (Urgently Needed Services- Not Yet Received)		Standard Appeals (Non-Urgent Services or Denied Claims)	
Level 1	Expedited Medical Review	Level 1	Informal Reconsideration *
Level 2	Expedited Appeal (Optional)	Level 2	Formal Appeal (Optional for Pre Service Appeals)
Level 3	Expedited External Independent Medical Review	Level 3	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from AzCH, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

**The Level 1 appeals processes are ONLY available for pre service denials. AzCH does not provide informal reconsideration of a denied claim. Claims payment, post service appeals begin at the formal appeal level (Level 2). Level 2 appeals are OPTIONAL for pre service appeals. You may skip Level 2 and ask for a Level 3 External Independent Review after you receive your Level 1 decision.*

**EXPEDITED HEALTH CARE APPEAL PROCESS
FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED**

Level 1. Expedited Medical Review

Your request: You may request an Expedited Medical Review for the denial of a service not already provided if:

- You have coverage with AzCH;
- AzCH denied your request for a covered service, AND
- Your treating provider certifies in writing and provides supporting documentation that the Level 1 Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition.

Available on our website in the Member Resources section, and the Provider Resource section is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information. Your treating provider must send the certification and documentation to:

Medical Contact: Utilization Management Level I Project Coordinator	Pharmacy Contact: Pharmacy Triage Coordinator
Medical Mail: 1870 W. Rio Salado Parkway Tempe, AZ 85281	Pharmacy Mail: 333 E. Wetmore Road Tucson, AZ 85705
Medical Email: AzCHPeerToPeer@azcompletehealth.com	Pharmacy Email: AzCH.PharmacyLevel1Appeal@azcompletehealth.com
Medical Fax: (833) 214-5522	Pharmacy Fax: (866) 256-6046
Toll Free Call: Customer Contact Center (888) 926-5057 ext. 84657 TTY/TDD (866) 918-4450	Toll Free Call: Customer Contact Center (888) 926-5057 ext. 6031278 TTY/TDD (866) 918-4450

If the expedited appeal request does not include the treating provider certification, AzCH reviews the appeal under the standard Level 1 process.

Our decision: AzCH has one business day after receiving the information from the treating provider to decide whether we should change our decision and authorize the requested service. The decision you receive includes the name, title, department, address, telephone number and fax number for the AzCH representative issuing the decision.

Within that same business day, we call and tell you and your treating provider our decision. We also mail you a written decision. The written decision explains the reasons for our decision and tells you the documents on which we based our decision.

- **If we deny your request,** you may immediately appeal to Level 2 or Level 3.
- **If we grant your request,** we authorize the service and the appeal is over.

- We have the option to decide to skip Levels 1 and 2 and **refer** your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal (Optional)

Your request: If we deny your request at Level 1, you may request a Level 2 Expedited Appeal. After you receive our Level 1 denial, your treating provider **must immediately** send us a written request (to the same person and address listed above) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us any more information (that the provider has not already sent us) to show why you need the requested service.

Our decision: We have three business days after we receive the request to make our decision.

- **If we deny your request,** you may immediately appeal to Level 3.
- **If we grant your request,** we authorize the service and the appeal is over.
- We have the option to decide to skip Levels 1 and 2 and **refer** your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Level 1. You have five business days after you receive our Level 1 or Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Contact:	Ambetter Appeals & Grievance Triage Coordinator
Email:	AzCHMarketplace2@azcompletehealth.com
Toll Free Call:	Customer Contact Center (888) 926-5057 TTY/TDD (866) 918-4450
Fax:	(877) 615-7734

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case: 1) Medical Necessity and 2) Contract Coverage.

Medical Necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Department of Insurance and Financial Institution, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

Contract Coverage

These are cases where we have denied coverage as not a covered a benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institution is the independent reviewer.

Medical Necessity Cases

Within one business day of receiving your request, AzCH mails a written acknowledgement of the request to you, the ADIFI Director, and your treating provider. The following is included in the mailing to the ADIFI Director:

- A copy of your request for a Level 3 review;
- A copy of your policy;
- Evidence of coverage or similar document;
- All medical records and supporting documentation used to render our decision;
- A summary of the applicable issues including a statement of our decision;
- The criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- The name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within two business days of receiving our information, the Insurance Director sends all the submitted information to an external independent reviewer organization (the “IRO”).

Within 72 hours of receiving the packet of information, the IRO makes a decision and send the decision to the ADIFI Director.

Within one business day of receiving the IRO’s decision, the Insurance Director mails a notice of the decision to you, your treating provider and AzCH.

The decision (medical necessity):

If the IRO decides that we should provide the service, AzCH authorizes the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within one business day of receiving your request, AzCH:

1. Mails a written acknowledgement of your request to the ADIFI, you, and your treating provider.
2. Sends the ADIFI Director the following:
 - A copy of your request for a Level 3 review;
 - A copy of your policy;
 - Evidence of coverage or similar document;
 - All medical records and supporting documentation used to render our decision;

- A summary of the applicable issues including a statement of our decision;
- The criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- The name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Contract Coverage Cases IRO Decisions: The ADIFI Director makes a coverage determination, issues a decision, and sends a written notice to AzCH, you, and your treating provider within two business days.

If the Director determines AzCH is responsible, we authorize the service or pay the claim.

In instances where the Insurance Director is sometimes unable to determine issues of coverage, the IRO completes a review in 72 hours. The Insurance Director has one business day after receiving the IRO's decision to send the decision to you, your treating provider and AzCH.

If you, your treating provider, or AzCH disagree with the ADIFI Director's final decision on a contract coverage issue, a request for a hearing with the Office of Administrative Hearings ("OAH") is filed within 30 days of receiving the Director's decision. OAH schedules and completes a hearing for appeals from expedited Level 3 decisions.

**Standard Appeal Process
For Non-Urgent Services and Denied Claims**

Level 1. Informal Reconsideration (Pre Service ONLY)

Your request: You, or your treating provider have two years from the initial denial to request a Level 1 Informal Reconsideration of your denied request for a service if:

- You have coverage with AzCH
- We denied your request for a covered service
- You do not qualify for an expedited appeal

Medical Contact: Utilization Management Level I Project Coordinator	Pharmacy Contact: Pharmacy Triage Coordinator
Medical Mail: 1870 W. Rio Salado Parkway Tempe, AZ 85281	Pharmacy Mail: 333 E. Wetmore Road Tucson, AZ 85705
Medical Email: AzCHPeerToPeer@azcompletehealth.com	Pharmacy Email: AzCH.PharmacyLevel1Appeal@azcompletehealth.com
Medical Fax: (833) 214-5522	Pharmacy Fax: (866) 256-6046
Toll Free Call: Customer Contact Center (888) 926-5057 ext. 84657 TTY/TDD 866-918-4450	Toll Free Call: Customer Contact Center (888) 926-5057 ext. 6031278 TTY/TDD 866-918-4450

Claim for a covered service already provided but not paid: You may not request a Level 1 Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking a Level 2 Formal Appeal.

We have five business days after we receive your request for a Level 1 Informal Reconsideration review request (“the receipt date”) to send you and your treating provider a notice that we got your request.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. Within that same 30 days, we send you and your treating provider our written decision. The written decision explains the reasons for our decision and tell you the documents on which we based our decision.

- If we **deny** your request, you have 60 days to appeal to Level 2 or Level 3.
- If we **grant** your request, the decision will authorize the service and the appeal is over.
- We have the option to decide to skip Levels 1 and 2 and **refer** your case straight to an independent reviewer at Level 3.

The decision you receive includes the name, title, department, address, telephone number and fax number for the AzCH representative issuing the decision.

Level 2 Formal Appeal (OPTIONAL for PRE SERVICE)

Your request: You may request a Level 2 Formal Appeal if:

- we deny your Level 1 Informal Reconsideration (Pre Service) or
- to dispute an unpaid (denied) claim payment (Level 1 Informal Reconsideration not an option for unpaid claim issues)

For Pre Service appeals, you, your designee, or your treating provider have 60 days after you receive our Level 1 denial, to send us a written request to appeal to Level 2 or Level 3.

You have 2 years from our initial denial notice or claims payments to request a Level 2 Formal Appeal.

To help us make a decision on your appeal, you or your treating provider should also send us any more information (that you have not already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Contact:	Ambetter Appeals & Grievance Triage Coordinator
Mail:	Ambetter from Arizona Complete Health Attention: Ambetter Appeals & Grievance PO Box 277610 Sacramento, CA 95827
Email:	AzCHMarketplace2@azcompletehealth.com
Fax:	(877) 615-7734
Toll Free Call:	Customer Contact Center (888) 926-5057 TTY/TDD 866-918-4450

Our acknowledgement: We send you and your treating provider a notice that we got your request within five business days after we receive your request for Formal Appeal (“the receipt date”).

Our decision: For a denied service that you have not yet received, we decide if we should change our decision and authorize the requested services within 30 days after the receipt date.

For denied claims, we decide if we should change our decision and pay your claim within 60 days of receiving your request for a formal appeal.

We send you and your treating provider our Level 2 appeal decision in writing. The written decision explains the reasons for our decision and tells you the documents on which we based our decision.

- **If we deny your request or claim,** you have four months to appeal to Level 3.
- **If we grant your request,** we will authorize the service or pay the claim and the appeal is over
- We have the option to decide to skip Levels 1 and 2 and **refer** your case straight to an independent reviewer at Level 3.

Level 3: External Independent Review

Your request: You may request a Level 3 review only after you have appealed through Level 1. You have four months after you receive our Level 1 or Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Contact	Ambetter Appeals & Grievance Triage Coordinator
Mail:	Ambetter from Arizona Complete Health Attention: Ambetter Appeals & Grievance PO Box 277610 Sacramento, CA 95827
Email:	AzCHMarketplace2@azcompletehealth.com
Fax:	(877) 615-7734

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

Medical Necessity Cases

Within five-business days of receiving your request, AzCH mails a written acknowledgement of the request to you, the ADIFI Director, and your treating provider. The following is included in the mailing to the ADIFI Director:

- A copy of your request for a Level 3 review;
- A copy of your policy Evidence of coverage or similar document;
- All medical records and supporting documentation used to render our decision;
- A summary of the applicable issues including a statement of our decision;
- The criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

- The name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within five business days of receiving our information, the Insurance Director sends all the submitted information to an external independent reviewer organization (the “IRO”).

Within 21 days of receiving the packet of information, the IRO makes a decision and send the decision to the ADIFI Director. The Director may extend the review timeframe an additional 31 days for good cause.

Within five business days of receiving the IRO’s decision, the Insurance Director mails a notice of the decision to you, your treating provider and AzCH.

If the IRO decides that we should provide the service, AzCH authorizes the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within five business days of receiving your request, AzCH:

1. Mails a written acknowledgement of your request to the ADIFI, you, and your treating provider.
2. Sends the ADIFI Director the following:
 - A copy of your request for a Level 3 review;
 - A copy of your policy;
 - Evidence of coverage or similar document;
 - All medical records and supporting documentation used to render our decision;
 - A summary of the applicable issues including a statement of our decision;
 - The criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
 - The name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

The ADIFI Director makes a coverage determination, issues a decision, and sends a written notice to AzCH, you, and your treating provider within 15 business days.

In instances where the Insurance Director is sometimes unable to determine issues of coverage, the ADIFI forwards the case to the IRO to complete a review within 21 days of receipt. The Insurance Director has five business days after receiving the IRO’s decision to send the decision to you, your treating provider and AzCH.

If you, your treating provider, or AzCH disagree with the ADIFI Director’s final decision on a contract coverage issue, a request for a hearing with the Office of Administrative Hearings (“OAH”) can be filed within 30 days of receiving the Director’s decision. OAH schedules and completes a hearing for appeals from Level 3 decisions.

Confidentiality

Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records are accessible to people authorized to participate in the review process for the medical condition under review. These people do not have permission from AzCH to disclose your medical information to any other people.

Access to Your Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. Your records are accessible to the person designated in writing unless you limit access to your medical records only to yourself or your health care decision-maker.

Documentation for a Health Care Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal filing. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also tell us the address and phone number we can contact you at regarding your appeal. If your appeals goes to Level 3, the Arizona Department of Insurance and Financial Institution receives your information.

Filing complaint with the ADIFI

Arizona law (ARS §20-2533(F)) requires you to exhaust the appeal process before you file a complaint with the ADIFI if your complaint involves a matter that could be appealed. You must pursue the health care appeals process before the ADIFI can investigate your complaint. The appeal process requires the ADIFI Director to:

- Oversee the appeals process.
- Maintain copies of each utilization review plan submitted by AzCH.
- Receive, process, and act on requests from AzCH for External, Independent Review.
- Enforce the decisions of AzCH.
- Review AzCH decisions.
- Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
- Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Written acknowledgments, requests, decisions or other written documents requiring mailing are deemed received by the person properly addressed to the last known address to on the 5th business day after being mailed. "Properly addressed" means your last known address.