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HB 2035: insurance; claims; appeals; provider credentialing
Sponsor: Representative Cook, LD 7
Caucus & COW

Overview

Establishes procedures and timeframes for when a health care insurer denies a health care service claim and provides a process for health care providers to request a hearing with the Office of Administrative Hearings (OAH) if their claim denial grievance is unresolved.

History

A *health care insurer* includes a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation and a medical service corporation, prepaid dental plan organization, dental service corporation or optometric service corporation.

Clean claims are written or electronic claims for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from the health care provider, the enrollee or a third party, except in fraud cases (A.R.S. § 20-3101).

Statute outlines the process for timely payment of health care provider's claims and to address grievances. Specifically, health care insurers must adjudicate any clean claim from a contracted or noncontracted health care provider relating to health care insurance coverage within 30 days after the health care insurer receives the clean claim or within the time specified by the contract.

If the claim is not a clean claim and the health care insurer requires additional information to adjudicate the claim, the health care insurer must send a written request for additional information to the contracted or noncontracted health care provider, enrollee or third party within 30 days after the health care insurer receives the claim. A health care insurer must not delay the payment of clean claims to a contracted or noncontracted provider or pay less than the amount agreed to by contract to a contracted health care provider without reasonable justification (A.R.S. § 20-3102).

Provisions

Denial of Health Care Service Claims

1. Requires health care insurers that deny a health care service claim in whole or in part, to provide to a health care provider at the time of the denial, contact information that includes a telephone number and an email address for an individual who is able to respond to questions about the claim denial. (Sec. 3)
2. Requires health care insurers, if requested by the health care provider, to provide the following information to them within 15 days after receiving the request:

a) if the denial was based on lack of medical necessity, a detailed reason why the health care service was not medically necessary and the health care provider's right to appeal;
b) a health care provider's right to dispute the health care insurer's decision that includes certain information on the dispute process and how to request a hearing; and
c) if the health care plan is not subject to regulation by the Arizona Department of Insurance and Financial Institutions (DIFI), a notification to the health care provider of the appropriate regulatory authority. (Sec. 3)

3. Directs health care insurers, within 30 days after receiving a written grievance, to respond in writing with their decision, unless the health care provider and insurer mutually agree to a longer period of time. (Sec. 3)

4. Requires a health care insurer's decision regarding the grievance to include:
a) the date of the decision;
b) the factual and legal basis for the decision;
c) the health care provider's right to request a hearing; and
d) the manner in which a health care provider may request a hearing. (Sec. 3)

5. Instructs a health care insurer to remit payment for the approved portion of the claim within 15 days after the date of the insurer's decision if they find in favor of the health care provider, in whole or in part. (Sec. 3)

6. Subjects a health care insurer's establishment of an internal system for resolving payment disputes and other contractual grievances with providers to the prescribed time periods for a health care service claim denial. (Sec. 2)

Health Care Provider Claim Dispute Hearing

7. Allows health care providers to submit a written request for a hearing to DIFI and must provide a copy of the request to the health care insurer within 30 days after receiving the health care insurer's decision or the date on which the provider should have received the health care insurer's decision if the provider's grievance is unresolved. (Sec. 3)

8. Requires DIFI to request a hearing with the OAH if a provider timely submits a hearing request to them. (Sec. 3)

9. Specifies that if the health care provider decides to withdraw their request for a hearing, they must send a written request for withdrawal to DIFI. (Sec. 3)

10. Directs DIFI to accept the written withdrawal request if it is received before DIFI requests an OAH hearing. (Sec. 3)

11. Specifies that if DIFI already submits a request for a hearing, the provider must promptly send a written request for withdrawal to OAH. (Sec. 3)

12. States that if a party to a decision issued seeks further administrative review, DIFI is prohibited from being a party to the action, unless it files a motion to intervene in the action. (Sec. 3)

Health Insurer Credentialing

13. Reduces the number of calendar days health care insurers must conclude the process of credentialing and loading an applicant's information into the health insurer's billing system from 100 to 45 calendar days after the date the health insurer receives a complete credentialing application. (Sec. 5)

14. Requires health care insurers to provide written or electronic confirmation:
    a) within two business days on receipt of a complete credentialing application; or
    b) within seven business days on receipt of a credentialing application with deficiencies. (Sec. 5)
15. Specifies that health care insurers must provide written or electronic notice of the approval or denial of a complete credentialing application to an applicant within seven days after the conclusion of the credentialing process. (Sec. 5)
16. Requires health care insurers to pay a claim for a covered service provided to a subscriber by a participating provider who has a fully executed contract with a network plan and whose credentialing application has been approved by the health insurer retroactively to the date of the participating provider's complete credentialing application. (Sec. 6)
17. Defines terms. (Sec. 1, 4)
18. Makes technical and conforming changes. (Sec. 1, 2, 4, 5)