Arizona Timely Pay & Grievance Law

Information for Health Care Providers

In 2000, the Arizona Legislature enacted the Timely Pay & Grievance law (TPG), governing the timely payment of health care provider claims. The law requires health care insurers to establish a system for processing disputes between providers and insurers.

In 2005, the law was amended to clarify requirements for claims processing, grievance systems, and payment adjustments.

This pamphlet from the Arizona Department of Insurance and Financial Institutions (the Department) summarizes the TPG law found in Arizona Revised Statute § 20-3102 and explains what assistance is available from the Department for health care providers.

DEFINITIONS

1. “Adjudicate" means an insurer's decision to deny or pay a claim, in whole or in part, including the decision as to how much to pay.
2. "Clean claim" means a written or electronic claim 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 cases of fraud.
3. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, prepaid dental plan organization, hospital service corporation, medical service corporation, dental service corporation, optometric service corporation, or hospital, medical, dental and optometric service corporation.

CLAIMS PROCESSING

The law requires that a health care insurer “shall **adjudicate** any **clean claim** from a contracted or noncontracted health care provider relating to health care insurance coverage within thirty days after the health care insurer receives the clean claim or within the time period specified by contract.”

1. If a claim is not clean, and an insurer requires additional information, the insurer must send a written request for the information within 30 days of receipt of the claim or within a time frame designated by contract. The insurer must specify the reason(s) it cannot adjudicate the claim.
2. An insurer must record the date it receives any additional information that the insurer requested.
3. An insurer may not require a provider to submit information a provider can document it has already provided, unless the insurer can provide reasonable justification and the purpose is not to delay the claim.

4. An insurer shall not request information from a contracted or noncontracted health care provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim.
5. An insurer shall 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.
6. The Department expects insurers to have a written policy available to providers that describes how providers may document they have already submitted the information the insurer wants them to resubmit.

ADJUDICATION AND PAYMENT

1. Under the law, adjudication and payment of clean claims are two separate steps. Adjudication is the decision regarding whether to pay or deny, in whole or in part, including the decision on the amount to pay.
2. Insurers must adjudicate clean claims within 30 days of receipt, or within a time frame designated by contract.
3. Insurers must pay any approved portions of clean claims within 30 days of adjudication, *or* within a time frame designated by its contract with a provider, if applicable.
4. Insurers that do not pay clean claims on time must pay interest at 10% per annum or another amount designated by contract. Interest begins accruing on the date payment was due.

ADJUSTMENTS

1. Neither an insurer nor a provider may request an adjustment of a claim more than one year after an insurer has paid or denied the claim. However,an insurer and provider may designate a different time limit for adjustment by contract provided that limit applies equally to the insurer and to the provider.

GRIEVANCES

A provider grievance is any written complaint subject to the law, except:

1. A complaint by a non-contracted provider about not being in an insurer's network.
2. A complaint by a provider about an insurer's decision to terminate the provider from the insurer's network.
3. An issue subject to health care appeals laws governing benefit coverage and/or medical necessity (A.R.S. § 20-2530 et seq.) See the Department's website for a separate brochure on the health care appeals laws. **Note:** Under Arizona law, providers may submit appeals to insurers on behalf of their patients.
4. Grievances can be submitted by contracted or non-contracted providers.
5. The law has no impact on contractual or policy provisions which are not addressed by the statute, including time periods for initial claim submission.

INSURER GRIEVANCE SYSTEMS

The law requires that each insurer establish and maintain an internal system for resolving payment disputes and other contractual grievances with health care providers. Each insurer:

1. Must have a written grievance policy that is available to providers upon request.
2. Must designate a contact person to receive grievances and answer provider questions on those grievances.
3. May recommend, but may not require, a specific form for the submission of grievances.
4. Must submit semi-annual grievance reports to the Department, which include information such as the number of grievances received by an insurer, the kinds of grievances, and the time to resolution.

ROLE OF THE DEPARTMENT

The TPG law does not provide the Department with the authority or resources to adjudicate individual claims or contracts between insurers and providers. Rather, the Legislature mandated that insurers establish and maintain an effective grievance system for provider disputes.

1. Providers should send grievance(s) directly to the insurer. If they are unsatisfied with the results, they may submit a grievance to the Department using the online Complaint Form found here: https://difi.az.gov/health-care-providers.
2. Grievances received by the Department that relate to denied claims or services will be rejected and the provider will be directed to submit an appeal.
3. If a provider calls or emails the Department about an unpaid claim or other grievance, the Department will refer the provider to the insurer's designated Grievance Contact Person.
4. The Department monitors the grievances from providers as well as the insurers' semi-annual grievance reports.
5. Providers that are unable to get a copy of an insurer's written grievance policy from an insurer, or who need the name of an insurer's grievance contact person, may contact the Department for assistance at providerinfo@difi.az.gov.

The Department only has authority to enforce the TPG law as it applies to payors under the Department's jurisdiction. The following payors are NOT under the Department's jurisdiction:

- AHCCCS (Medicaid)
- Medicare
- Worker's Compensation
- Federal Employee Benefit Programs
- County/Municipal Health Systems
- Self-Insured Employer Plans
- Insurers Not Authorized in Arizona
- Plans under tribal jurisdiction

Visit the Department's Health Care Provider webpage for dispute resolution resources associated with these types of benefits.

MORE INFORMATION:

The Department's website: https://difi.az.gov/health-care-providers

Timely Pay & Grievance Statutes: A.R.S. §§ 20-3101 through 20-3102

The Department's Regulatory Bulletins:

- Regulatory Bulletin 2006-02 - https://difi.az.gov/sites/default/files/documents/files/2006-02.pdf

- Circular Letter 2000-15 https://difi.az.gov/sites/default/files/documents/files/2000-15.pdf

QUESTIONS?

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Updated August 2023