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DEPARTMENT OF INSURANCE
& FINANCIAL INSTITUTIONS

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REGULATORY BULLETIN[1] 2025-01 (INS)

TO: Life and Disability Insurers, Health Care Services Organizations, Hospital, Medical, Dental and Optometric Service Corporations, Life and Health Insurance Administrators, Third Party Intermediaries, Professional Associations and Interested Parties

From: Barbara Richardson

Date: February 3, 2025

RE: **Health Care Provider Timely Payment and Grievance Law.**

This Regulatory Bulletin supersedes and replaces the Department's prior guidance on this subject including Circular Letter 2000-15 (withdrawn previously) and Regulatory Bulletin 2006-02 - Health Care Provider Timely Payment and Grievance Law, which is hereby withdrawn.

1. Introduction

The Timely Pay and Grievance Law reflects legislative recognition that both timely, accurate payment to providers and prompt resolution of their grievances are essential components of a functional health care insurance system. The "Managed Care Accountability Act" [Laws 2000, Ch. 37 (HB 2600)] enacted Arizona's Timely Payment and Grievance Law and established requirements for health care insurers ("insurers") to: (1) process and pay health care provider ("provider") claims according to certain standards; (2) establish an internal system for resolving provider grievances; and (3) report to the Department of Insurance (now Department of Insurance and Financial Institutions) ("Department") on those grievances.

In 2024, the legislature amended the Timely Pay and Grievance Law to expand definitions and outline new reporting requirements for the Department. [Laws 2024,

[1] This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties, you may petition the agency under ARS § 41-1033 for a review of the Statement.

Ch. 72 (HB 2444)].[2] The legislature enacted the following notable changes to the law:

1. HB2444 revised the definition of "grievance" at ARS § 20-3101(4) to add a new subsection (b): "Grievance": (a) Means any written complaint that is subject to resolution through the insurer's system that is prescribed in section 20-3102, subsection F and submitted by a healthcare provider and received by a healthcare insurer. (b) Includes any delay in the timeliness of claim adjudication that results in a delay of payment as prescribed in section 20-3102. (c) Does not include a complaint: (i) By a non-contracted provider regarding an insurer's decision to deny the noncontracted provider admission to the insurer's network. (ii) About an insurer's decision to terminate a health care provider from the insurer's network. (iii) That is the subject of a health care appeal pursuant to chapter 15, article 2 of this title.

2. HB2444 revised ARS § 20-3102 to impose a new reporting requirement upon the Department with new subsection (I): (I). On or before August 1 of each year, the Director shall post a report on the Department's publicly accessible website that includes the information prescribed in subsection F of this section for the prior fiscal year and that includes: 1. The total number of grievances received. 2. The average time to resolve a grievance. 3. The percentage of grievances where a health care insurer decision was overturned.

3. HB2444 revised ARS § 20-3102 to clarify provider rights to payment with new subsection (M): (M). This section does not preclude a health care provider, with written informed consent of the patient, from collecting monies for a medical service that is either: 1. Not covered under the insurance policy. 2. Medically necessary and a payment on the claim was not made due to a denial on the basis of frequency or a disallowance on the basis of frequency. For the purposes of this paragraph, a provider is limited to the rates prescribed by that provider's fee schedule.

This Regulatory Bulletin restates the requirements under the law (ARS §§ 20-3101 and 20-3102) and reviews the Department's planned implementation of new amendments passed under HB2444.

2. Clean Claims

By defining "clean claim," the legislature acknowledged that providers have an obligation to submit clean claims if they expect insurers to pay claims on a timely basis. ARS § 20-3101(2). A claim is not "clean" if an insurer cannot determine whether to approve or deny it without obtaining additional information including, among other things, coordination of benefits ("COB") information. An insurer making

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[2] HB2444 also made changes to ARS § 20-241 to address acceptance of checks as an acceptable form of payment and to add clarifying language to ARS § 20-3115. Neither of these changes impact the Timely Pay and Grievance Law.

a reasonable effort to obtain additional information in order to process a claim may pend that claim in order to request the necessary information. *See*, ARS § 20-3102(B) and Section 4(A) “Requesting and Handling Additional Information,” below.

3. Claims Processing; Contract Provisions

ARS § 20-3102(A) establishes a bifurcated claim-handling process. An insurer has 30 days from receipt of a clean claim to adjudicate the claim and 30 days from the date of adjudication to pay any approved portion of the adjudicated claim. As a result, insurers must be able to identify, by date, at least three points in the processing of a claim that is clean when the insurer first receives it: (1) receipt; (2) adjudication; and, (3) payment or denial. Two or more of these points may occur on the same date.

ARS § 20-3102(A) provides that an insurer and a provider may contract for an adjudication period, or payment period, that varies from the statutory requirement of 30 days each. If the provider and insurer contract for non-statutory periods, then the contract governs the length of the periods, but failure to adjudicate or pay within the applicable contractual period is still a violation of Title 20.

The timely pay and grievance law contemplates that an insurer-provider contract can modify some statutory requirements, however, an insurer and a provider may not enter into a contract that negates the law. For example, ARS § 20-3102(A) does not permit an insurer to contract with a provider to eliminate the bifurcated receipt-to-adjudication and adjudication-to-payment periods and replace them with a single claim-processing period from receipt to payment. To illustrate: An insurer may enter into a contract with a provider that allows the insurer 15 days to adjudicate a clean claim and 15 days to pay it, if approved. However, the insurer may not enter into a contract with a provider that simply allows the insurer to pay an approved clean claim within 30 days of receiving it.

ARS § 20-3102(A) mandates that, if an insurer fails to timely pay claims, the insurer must pay interest at the legal rate, beginning on the date payment was due. The legal interest rate, as defined in ARS § 44-1201, is 10% per annum. The insurer and provider may contract in writing for a different, reasonable rate but, they may not enter into a contract that excuses the insurer from paying any interest at all.

ARS § 20-3102 has no impact on contractual provisions that the statute does not address, such as time periods for the submission of claims, or the submission of additional information.

4. Additional Information

ARS § 20-3102(B) provides, “If the claim is not a clean claim and the health care insurer requires additional information to adjudicate the claim, the health care insurer shall send a written request for additional information…within thirty days after the health insurer receives the claim.” Further, ARS § 20-3102(B) requires,

"The health care insurer shall notify the… health care provider of all the specific reasons for delay in adjudicating the claim. The health care insurer shall record the date it receives the additional information and shall adjudicate the claim within thirty days after receiving all additional information."

A. Requesting and Handling Additional Information

An insurer may "pend" or otherwise set aside an unclean claim, but may not deny it before requesting additional information. Compliance with this requirement does not hinge on how an insurer labels the unclean claim. Compliance depends on how the insurer handles the claim, i.e., whether the insurer links the additional information to the original claim and adjudicates the original claim (a compliant process), or whether the insurer fails to link additional information to the original claim and handles the additional information as a new claim (a noncompliant process).

ARS § 20-3102(B) requires that if an insurer requests additional information regarding an unclean claim, the insurer must record the date it receives the additional information. This information is important to determine whether an insurer is complying with ARS §§ 20-3102(B), (D) and (E), where compliance hinges on the date an insurer receives additional information.

ARS § 20-3102(B) further requires that when an insurer receives all the additional information, it has 30 days to adjudicate the claim and pay any approved portion. This is a single period, not bifurcated in the same manner as the receipt-to-adjudication and adjudication-to-payment periods established under ARS § 20-3102(A). Insurers must identify, by date, at least five points in the processing of a claim that is not clean when the insurer receives it: (1) receipt; (2) request for additional information; (3) receipt of all additional information; (4) adjudication of the original claim using the additional information; and, (5) payment or denial.

An insurer and a provider are free to contract for a non-statutory single period under ARS § 20-3102(B). They are not free, however, to contractually substitute bifurcated periods for this single period. The legislature created the bifurcated periods only for claims that are clean when the insurer first receives them and created a single period for processing pended claims when all additional information is received.

B. Requesting COB Information

An insurer making a reasonable effort to obtain COB information in order to process a claim may pend a claim in order to request the necessary information. Indications of a reasonable effort in this context might include, but are not limited to: (1) a documented basis for the insurer's belief that COB is available or appropriate, such as information on file regarding an enrollee's alternate coverage; and, (2) a documented effort by the insurer to obtain the COB information promptly.

C. Requesting Medical Information
When a claim is clean except for medical information, the insurer may only request medical information relating to the medical condition at issue. *See,* ARS § 20-3102(D).

D. Requesting Information the Provider Has Already Submitted
An insurer may not require a provider to resubmit information the provider can demonstrate it already has provided to the insurer. *See,* ARS § 20-3102(E). To make compliance and enforcement of this provision feasible, an insurer must establish and advise providers of a written policy describing how providers may document their prior submission of the requested information, without the provider having to resubmit the information as proof of the initial submission. For example, such a policy might state that the provider may record the submission in a log that the provider keeps as a regular business practice, or the provider may submit proof of an electronic filing.

5. Provider Grievances

ARS § 20-3102(F) requires insurers to establish an internal system for resolving payment disputes and other provider grievances.

A. Purpose of Statutory Grievance System Requirements
This requirement is pivotal to the effectiveness of the timely pay and grievance law, especially because the law "does not require or authorize the Director to adjudicate individual contracts or claims between health care insurers and health care providers." *See,* ARS § 20-3102(H). Rather, the law places the duty on every insurer to establish an internal system for resolution of provider disputes. The Department's role is to verify that an insurer's grievance system is effective.

B. Characteristics of a Grievance
ARS § 20-3101(4) defines "grievance" as "any written complaint that is subject to resolution through the insurer's system that is prescribed in section 20-3102, subsection F and submitted by a provider and received by a health care insurer." *See,* ARS § 20-3101(4)(a). A "grievance" also includes "any delay in the timeliness of claim adjudication that results in a delay of payment of a clean claim as prescribed in section 30-3102." *See,* ARS § 20-3101(4)(b).
A grievance is **not** any of the following:

- A provider's complaint regarding denial of admission to an insurer's network. *See,* ARS § 20-3101(4)(c)(i).
- A provider's complaint regarding termination from an insurer's network. *See,* ARS § 20-3101(4)(c)(ii).
- A complaint that is the subject of a health care appeal under ARS § 20-2530 *et seq. See,* ARS § 20-3101(4)(c)(iii).

Moreover, the definition of "grievance" is not limited to payment disputes, or to contracted provider grievances. Insurers may have payment disputes with both contracted and non-contracted providers and will need a grievance system that accommodates and reports payment disputes regardless of the contract status of the provider. At the same time, the grievance system must accommodate grievances from both contracted and non-contracted providers about matters other than payment disputes, including, but not limited to systemic or operational problems, quality assurance problems, or network adequacy problems unrelated to the provider's contract status.

C. Characteristics of an Internal Grievance System

The law reflects the legislature's intent that an insurer has both the opportunity and the operational ability to promptly correct its own mistakes. The Department recognizes that insurers' systems may vary, particularly depending on their product structure and networks, however, the Department expects an insurer's grievance system to be effective and to include the following basic characteristics:

1. The insurer should describe its system in a written set of policies and procedures, readily available to providers upon request. An insurer's grievance policy should specify the minimum information the insurer needs in order to resolve the grievance and the number of days in which the insurer will do so.

2. Insurers should strive for an administratively simple system that: (a) providers can readily follow; (b) encourages providers to bring legitimate grievances; and, (c) provides for prompt dispute resolution.

3. The insurer representative responsible for resolving the grievance should be someone other than the person who made the initial decision giving rise to the grievance, and should be someone in a different chain of command (i.e. a neutral "third party").

4. The system should afford the provider a reasonable opportunity to present information related to the dispute, and to communicate with the decision maker, orally or in writing, as appropriate.

5. Insurers may encourage providers to use a particular form for certain grievances, but may not require them to do so. The Department will consider a communication as a grievance, even if its format is informal, or does not specifically use the words, "this is a grievance…"

6. A grievance is not dependent on nomenclature and insurers may use a term other than "grievance" to refer to grievances.

Nonetheless, the Department encourages insurers to use the term "grievance," because, for example, referring to grievances as "appeals" increases the potential for confusion between a health care appeal and a provider grievance, or referring to grievances as "inquiries" may create a misleading impression regarding an insurer's duties to process such grievances according to law. *See*, Section 5(D) "Grievances Distinguished from Health Care Appeals," below.

7. An insurer that has a tiered grievance process must record and report grievances to the Department beginning on the lowest tier. For example, an insurer may have a process which labels grievances as "inquiries". If the provider rejects the outcome of an inquiry, he or she may file an "appeal". If the provider does not like the outcome of an appeal, he or she may file a "grievance." Such a tiered system complies with ARS § 20-3102(F) as long as:
    - The process is administratively simple (*See*, Section 5(C)(2), "Characteristics of an Internal Grievance System," above); and,
    - The insurer records and reports the first tier "inquiry" as a grievance to the Department.

D. <u>Grievances Distinguished from Health Care Appeals</u>

The Department has received many questions about the difference between a health care appeal (HCA) and a provider grievance. The timely pay and grievance provisions set forth in ARS §§ 20-3101 and 20-3102 neither limit nor expand the HCA process established under ARS § 20-2530 *et seq.* The HCA process permits an enrollee to appeal if the insurer, having conducted utilization review, refuses to authorize a service, or pay a claim, because the insurer believes the service is not covered, or is not medically necessary. Providers often assist their patients in pursuing health care appeals and may pursue such appeals on behalf of patients. *See*, ARS § 20-2530(1), which defines "member" to include an enrollee's treating provider.

Providers appropriately acting on behalf of enrollees may bring a health care appeal for a denial of payment or request for service to the extent allowed under the appeals process. *See*, ARS § 20-2530 *et seq.*[3] On the other hand, a provider should use an insurer's internal grievance system (established under ARS § 20-3102(F)) to: (1) submit, on their own behalf, grievances of the types listed in Section 6 - Type of Grievance Table below; and, (2) address payment denials relating to coverage, or medical necessity, that may not be subject to the HCA process.

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[3] For a HCA, "'Claim' does not include claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers." A.R.S. § 20-2501(A)(3)(b). "'Denial' does not include enforcement of a health care insurer's deductibles or coinsurance requirement or adjustments for a service or coordination of benefits between health care insurers." A.R.S. § 20-2501(A)(5)(c).

6. Grievance Records

ARS § 20-3102(F) requires insurers to maintain records of provider grievances on a grievance-by-grievance basis. *See also*, Section 7(B), "Counting and Categorizing," below. The grievance records must include the information listed in ARS § 20-3102(F) and any additional information the Director requires.[4]

A. Statutory Record-Keeping Requirements

1. Name and identification number of the provider who filed the grievance. Note: Recording a provider grievance under the enrollee's name is not in compliance with this requirement.

2. Type of grievance from the Type of Grievance Table.
Type of Grievance Table.

Grievance Type No.	Description/Basis for Dispute
1	Whether the claim was clean.
2	Failure to timely pay claim.
3	Amount paid (bundling software).
4	Amount paid (other than bundling software).
5	Amount of timeliness of interest payment.
6	Coverage under enrollee's policy (e.g. benefit exclusion, medical necessity, etc.).
7	Pre-authorization/pre-certification/notification.
8	Adjustment request.
9	Network adequacy (other than the provider's contract status).
10	Systemic or operational problems.
11	Other.

3. Date the insurer received the grievance.

4. Date the insurer resolved the grievance.

B. Additional Record-Keeping Information the Director Requires:

1. Any records necessary to support the Semi-Annual Statutory Grievance Report. *See,* Section 7, "Semi-Annual Statutory Grievance Report," below.

[4] HB2444 adds that "on or before August 1 of each year, the Director shall post a report on the Department's publicly accessible website that includes the information prescribed in subsection F of this section for the prior fiscal year that includes: (1) the total number of grievances received (2) The average time to resolve a grievance (3) The percentage of grievances where a health care insurer's decision was overturned." *See*, ARS § 20-3102(I).

2. Number of grievances, if any, preempted under Center for Medicare and Medicaid Service guidelines for Medicare Advantage coverage determinations. *See*, Section 11(C), "Scope and Application of Timely Pay and Grievance Law; Medicare Advantage Preemption," below.

3. Number of claims adjudicated during the reporting period. An insurer should not record non-clean claims as adjudicated until after the insurer has received all additional information and linked the information to the original claim. *See*, Section 4(A), "Requesting and Handling Additional Information," above.

7. Semi-Annual Statutory Grievance Report

The law requires insurers to file semi-annually with the Department a grievance report that summarizes all grievance records. *See,* ARS § 20-3102(F). The report consists of two sections:
1) Grievance Summary sheet which reports the total number of grievances, the average time to resolve a grievance, the percentage of grievances where the healthcare insurer's decision was overturned and the percentage of all adjudicated claims which were the subject of a provider grievance.
2) Grievance Statistics sheet which includes provider name and identification number, grievance type, resolution type, date received, date resolved and number of days to resolve.

Purpose of Semi-Annual Statutory Grievance Report

The Semi-Annual Statutory Grievance Report is a critical monitoring tool that provides the Department with important information about the insurer, its network, and its ability to pay claims and provide services to enrollees. It can serve as an indicator of, among other things, solvency problems, network inadequacies and quality assurance deficiencies.

A. Counting and Categorizing Grievances

For reporting as well as record-keeping purposes, an insurer must categorize each grievance it receives into one of eleven grievance types listed in the Type of Grievance Table. (*See,* Section 6(A)(2), above) An insurer must separately treat each claim submitted as an individual grievance. For example, if a provider files a written notice that an insurer failed to pay interest on twenty late-paid claims, the insurer must record that filing as twenty grievances, not one grievance.
On the other hand, an insurer need not record more than one grievance per claim. For example, if a provider files a written notice that an insurer made three errors processing one claim, the insurer need not record each error as a separate grievance, but may record the entire incident as a single grievance, categorized according to the provider's primary concern.

B. Timing and Format of Semi-Annual Statutory Grievance Reports

For the April 1, 2025 Report: Insurers are required to submit 2 reports:
1) for the entire fiscal year 2024 (July 1, 2023 through June 30th, 2024).
2) for the first half of fiscal year 2025 (July 1, 2024 through December 31, 2024).

Thereafter, a Semi-Annual Statutory Grievance Report is due each October 1 for grievances an insurer receives between January 1 and June 30 of that year, and each April 1 for grievances an insurer receives between July 1 and December 31 of the prior year. A report filed on October 1 should include all data available about the resolution of grievances received between January 1 and June 30 and resolved on or before August 31 of that year. A report filed on April 1 should include all data available about resolution of grievances received between July 1 and December 31 of the prior year and resolved on or before February 28 (or February 29, if applicable) of the current year. *See*, SERFF Instruction for the format and content specifications for the Semi-Annual Statutory Grievance Report.

Filing requirements, instructions and required forms are available in SERFF.

8. The Role of the Department

Providers should file original grievances **with the insurer**, not with the Department.

The Department monitors the grievance-related correspondence and calls that it receives from providers. Multiple grievances or calls related to a single insurer may indicate the insurer has systemic or other regulatory compliance problems. The Department uses the information in the Semi-Annual Statutory Grievance Reports to determine whether patterns exist that raise regulatory concerns.

If a provider contacts the Department regarding disputes not within the Department's jurisdiction, the Department staff will refer them to the entity having jurisdiction.

The Department has the authority to investigate complaints of alleged Title 20 violations that do not involve the adjudication of a claim or a contract dispute. For example, if a provider alleges that an insurer has failed to address a grievance, or failed to provide a copy of its grievance policy upon request, the Department may investigate the complaint and will take appropriate measures to enforce Title 20.

The law does not provide any right of appeal to the Department for a provider dissatisfied with the results of an insurer's internal grievance system.

9. Payment Adjustments

ARS § 20-3102(J) provides that an insurer or provider shall not adjust or request adjustment of a payment or denial of a claim more than one year after the insurer has paid or denied the claim.

A. Payments of $0.00
   A denial counts as "payment" of $0.00 for purposes of starting the clock on the adjustment period.

B. Contract Provisions
   ARS § 20-3102(J) provides that if the insurer and provider agree by contract on a length of time to adjust or request adjustment of the payment of a claim, the insurer and provider must have equal time to adjust or request adjustment of the payment of the claim. For example, if a provider contract states that the provider has no more than eight months after a payment to make or request an adjustment, it also must limit the insurer to eight months after payment to make or request an adjustment. Notwithstanding this provision, an insurer cannot contract for an unreasonably limited adjustment period.

C. Impact of COB on Adjustment Period
   Fraud is the only exception to the adjustment period. Once the adjustment period expires, an insurer may not adjust a payment on subsequent discovery of a possible basis for COB, or that Medicare was the primary payor. *See*, Section 2, "Clean Claims," above. An insurer expressly may take the time it reasonably needs to obtain COB or primary payor information before it adjudicates a claim. Once an insurer pays or denies a claim, neither the insurer, nor the provider, may extend the adjustment period for any reason other than fraud.

D. Interest Obligations After Adjustment
   ARS § 20-3102(J) provides that an insurer does not owe interest on an unpaid or underpaid claim as long as the insurer makes the full payment within 30 days of the date of the claim adjustment. The Department assumes that the date of the claim adjustment is the date the insurer re-adjudicates the claim following the adjustment request.

   ARS § 20-3102(J) further states that a provider does not owe interest on an overpayment as long as the provider makes the repayment within 30 days of the date of the claim adjustment. This provision does not create an obligation on the part of the provider to pay interest after a recoupment.

10. Change of Filing Locations

In the event an insurer changes the location (address) at which providers must file claims or grievances, ARS § 20-3102(L) provides that, for 90 days after the insurer changes the location, the insurer must consider a claim or grievance delivered to the original location to be "properly received" and must provide prompt written notification to the provider of the change of location. *See,* ARS § 20-3102(L)(1) and (2).

If a provider sends a claim or grievance to a changed location more than 90 days after the effective date of the change, the insurer may, but is not required to, consider it properly received. Pursuant to ARS § 20-3102(L), an insurer may not

reject a claim or grievance that it timely receives at a correct new location solely because the provider first sent it to an address that was no longer correct.

11. Scope and Application of Timely Pay and Grievance Law

A. Types of Insurers

The law contains no exclusions for particular types of insurance claims or particular insurers and applies to all claims and grievances that providers submit to insurers, including:

- Disability (indemnity) insurers doing business in the group or individual markets.
- Service corporations governed by ARS § 20-821 *et seq*.
- Health care services organizations (HMOs) governed by ARS § 20-1051 *et seq*.
- Prepaid dental plan organizations governed by ARS § 20-1001 *et seq*.

The law does not apply to payors that are not health care insurers or to programs where federal law preempts the state timely pay and grievance law, including:

- Self-insured or self-funded employer plans.
- AHCCCS.
- County governments.
- Workers' Compensation.
- Federal Employee Health Benefit Programs.
- Medicare fiscal intermediaries paying Medicare fee-for-service claims.
- Medicare Advantage (certain exceptions described below).

An insurer that provides the Department with claims data or grievance data for any reason should exclude data for payors or programs to which state law does not apply.

B. Types of Providers

ARS § 20-3102 explains that the timely pay and grievance law applies to claims and grievances from both contracted and non-contracted providers and out-of-state providers who provide covered services to Arizona enrollees.

Note that the timely pay and grievance law does not define the term "health care provider," whereas, the term "health care professional" is defined elsewhere in the statutes to include individuals licensed under ARS Titles 32 or 36. By choosing the broader term "health care provider," as opposed to "health care professional," the legislature allowed for a more expansive interpretation of the timely pay and grievance law to include those persons who provide health or medical services or goods to an insurer's enrollee, including hospitals, health care professionals, durable medical goods suppliers, pharmacies, and ancillary providers.

C. Medicare Advantage Preemption

The Medicare Prescription Drug, Improvement and Modernization Act ("MMA") preempts state standards "other than State licensing laws or State laws relating to plan solvency." *See*, Section 1856(b)(3) of the Social Security Act, as amended by Section 232 of the MMA; 42 CFR § 422.402. Thus, MMA preempts the timely pay provisions for all Medicare claims.

MMA also preempts the grievance provisions for Grievance Type Nos. 1-8, but does not preempt grievance provisions for Grievance Type Nos. 9 & 10. *See*, Type of Grievance Table, Section 6(A)(2), above, and the instructions in SERFF. Grievance Type Nos. 9 and 10 fall under HCSO state licensure laws because they are elements of an "appropriate mechanism to achieve an effective health care plan" which is a licensure requirement under ARS § 20-1054(A)(2). An insurer should exclude data on preempted Medicare grievances in its Semi-Annual Statutory Grievance Report (*See*, Section 7 – Semi-Annual Statutory Grievance Report, above), or in any other grievance data provided to the Department, although an insurer must be prepared to account for any data excluded from its Semi-Annual Statutory Grievance Report.

12. Delegation of Functions

An insurer cannot escape responsibility under ARS §§ 20-3101 and 20-3102 by delegating authority to a third party. The law applies to the activities of third party intermediaries (TPIs) as defined in ARS § 20-120(K)(7), third party administrators (TPAs) as defined in ARS § 20-485(A)(1) and unregulated third parties that insurers use to perform provider claims or grievance functions. If an insurer contracts with a TPI, TPA or other third party, the contract must require compliance with ARS §§ 20-3101 and 20-3102. In addition, each insurer is affirmatively responsible for monitoring the performance of its delegates to ensure that the performance complies with the law. The Department will hold each insurer responsible for its delegate's performance in fulfilling the insurer's statutory responsibilities.

13. Conflicts with ARS § 20-462

ARS § 20-462 is an older statute governing timely payment of first party claims that applied to claims of a "provider who has been assigned the right to receive benefits under the contract by the insured." ARS § 20-462(D). It required an insurer to pay interest on first party [clean] claims not paid within 30 days of the insurer's receipt of an acceptable proof of loss (payable from the date the insurer receives the clean claim).

The payment time period and interest accrual period in ARS § 20-462 directly conflict with the provisions of ARS § 20-3102(A). Under the timely pay law, an insurer must approve, but not necessarily pay, a clean claim within 30 days of receipt. The insurer has an additional 30 days after approval to issue payment and interest accrues from the payment due date, rather than from the date the insurer received the clean claim.

The timely pay law governs health care insurer payment to health care providers

more specifically than does ARS § 20-462. The timely pay law supersedes ARS § 20-462 as it previously applied to the timing of payments to health care providers, and any implementing rule such as A.A.C. R20-6-801, and substantive policy statements such as Regulatory Bulletin 93-1. Webb v. Dixon, 104 Ariz. 473, 475-76, 455 P.2d 447, 449-50 (1969); Alexander v. Fund Manager, Public Safety Personnel Retirement System, 166 Ariz. 589, 593, 804 P.2d 122, 126 (Ct. App. 1990).

This Regulatory Bulletin reaffirms that:

- The Director expressly withdraws Regulatory Bulletin 2006-02 as of the issuance of this Regulatory Bulletin.
- The Unfair Claims Settlement Practices Act (ARS § 20-462) and any implementing rules continue to apply to treatment of claims for reimbursement to enrollees who have paid providers directly for covered out-of-network services.

14. Insurer Contact for Provider Grievances; Notice to the Department

Each health care insurer must designate one person as the primary contact for all questions (from providers and the Department) relating to provider grievances. The insurer must provide any updated contact for provider grievances, and submit to the Department the individual's name, title, address, telephone number, and e-mail address.

Insurers should submit this information by e-mail to: providerinfo@difi.az.gov.

When a provider erroneously contacts the Department regarding a matter appropriate for resolution through the insurer's grievance process, the Department will advise the provider to contact the insurer's provider grievance primary contact person for help.

15. Effective Date

The amendments to ARS § 20-3102(I) apply to grievances that an insurer receives on, or after, July 1, 2024, and are subject to the grievance reporting timelines described in Section7(C), "Timing and Format of Semi-Annual Statutory Grievance Reports," above.

Any person who has questions may contact the Department at 602-364-3100 or providerinfo@difi.az.gov.