PREFILED DEC 08 2023

REFERENCE TITLE: insurance; claims; appeals; provider credentialing

State of Arizona
House of Representatives
Fifty-sixth Legislature
Second Regular Session
2024

HB 2035

Introduced by
Representatives Cook: Sandoval

AN ACT

AMENDING SECTIONS 20-3101 AND 20-3102, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 20, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-3103 AND 20-3104; AMENDING SECTIONS 20-3451, 20-3453 AND 20-3456, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-3101, Arizona Revised Statutes, is amended to read:

20-3101. Definitions

In this article, unless the context otherwise requires:

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. "Enrollee" means an individual who is enrolled under a health care insurer's policy, contract or evidence of coverage.

4. "Grievance" 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 health care provider and received by a health care insurer. Grievance does not include a complaint:

(a) By a noncontracted provider regarding an insurer's decision to deny the noncontracted provider admission to the insurer's network.

(b) About an insurer's decision to terminate a health care provider from the insurer's network.

(c) That is the subject of a health care appeal pursuant to chapter 15, article 2 of this title.

5. "HEALTH CARE FACILITY" MEANS A HOSPITAL, OUTPATIENT SURGICAL CENTER, HEALTH CARE LABORATORY, DIAGNOSTIC IMAGING CENTER OR URGENT CARE CENTER.

~~5.~~ 6. "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."

7. "HEALTH CARE PLAN":

(a) MEANS A PLAN OFFERED BY A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION THAT CONTRACTUALLY AGREES TO PAY OR MAKE REIMBURSEMENT FOR HEALTH CARE EXPENSES FOR ONE OR MORE INDIVIDUALS WHO RESIDE IN THIS STATE.

(b) DOES NOT INCLUDE LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

8. "HEALTH CARE PROVIDER" MEANS:

(a) A PERSON WHO IS LICENSED, REGISTERED OR CERTIFIED AS A HEALTH CARE PROFESSIONAL PURSUANT TO TITLE 32.

(b) A HEALTH CARE FACILITY THAT FURNISHES SERVICES TO AN ENROLLEE AND THAT SEPARATELY BILLS FOR SERVICES.

9. "HEARING" MEANS AN ADMINISTRATIVE HEARING UNDER TITLE 41, CHAPTER 6, ARTICLE 10.

Sec. 2. Section 20-3102, Arizona Revised Statutes, is amended to read:

20-3102. Timely payment of health care providers' claims; grievances

A. 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. Unless there is an express written contract between the health care insurer and the health care provider that specifies the period in which approved claims shall be paid, the health care insurer shall pay the approved portion of any clean claim within thirty days after the claim is adjudicated. If the claim is not paid within the thirty-day period or within the time period specified in the contract, the health care insurer shall pay interest on the claim at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the health care provider is due.

B. 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 to the contracted or noncontracted health care provider, enrollee or third party within thirty days after the health care insurer receives the claim. The health care insurer shall notify the contracted or noncontracted health care provider of all of the specific reasons for the 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 the additional information. The health care insurer shall also pay the approved portion of the adjudicated claim within the same thirty-day period allowed for adjudication or within the time period specified in the provider's contract. If the health care insurer fails to pay the claim as prescribed in this subsection, the health care insurer shall pay interest on the claim in the manner prescribed in subsection A OF THIS SECTION.

C. A health care 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.

D. A health care 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.

E. A health care insurer shall not request a contracted or noncontracted health care provider to resubmit claim information that the contracted or noncontracted health care provider can document it has already provided to the health care insurer unless the health care insurer provides a reasonable justification for the request and the purpose of the request is not to delay the payment of the claim.

F. SUBJECT TO THE TIME PERIODS PRESCRIBED IN SECTION 20-3103, a health care insurer shall establish an internal system for resolving payment disputes and other contractual grievances with health care providers. The director may review the health care insurer's internal system for resolving payment disputes and other contractual grievances with health care providers. Each health care insurer shall maintain records of health care provider grievances. Semiannually each health care insurer shall provide the director with a summary of all records of health care provider grievances received during the prior six months. The records shall include at least the following information:

1. The name and any identification number of the health care provider who filed a grievance.

2. The type of grievance.

3. The date the insurer received the grievance.

4. The date the grievance was resolved.

G. On review of the records, if the director finds a significant number of grievances that have not been resolved, the director may examine the health care insurer.

H. This section does not require or authorize the director to adjudicate the individual contracts or claims between health care insurers and health care providers.

I. Except in cases of fraud, a health care insurer or contracted or noncontracted health care provider shall not adjust or request adjustment of the payment or denial of a claim more than one year after the health care insurer has paid or denied that claim. If the health care insurer and health care provider agree through contract on a length of time to adjust or request adjustment of the payment of a claim, the health care insurer and health care provider must have the same length of time to adjust or request adjustment of the payment of the claim. If a claim is adjusted, neither the health care insurer nor the health care provider shall owe interest on the overpayment or underpayment resulting from the adjustment, as long as the adjusted payment is made or recoupment taken within thirty days of the date of the claim adjustment.

J. This article does not apply to licensed health care providers who are salaried employees of a health care insurer.

K. If a contracted or noncontracted health care provider files a claim or grievance with a health care insurer that has changed the location where providers were instructed to file claims or grievances, the health care insurer shall, for ninety days following the change:

1. Consider a claim or grievance delivered to the original location properly received.

2. Following receipt of a claim or grievance at the original location, promptly notify the health care provider of the change of address through mailed written notice or some other written communication.

L. Any claim that is subject to article 2 of this chapter is not subject to this article.

Sec. 3. Title 20, chapter 20, article 1, Arizona Revised Statutes, is amended by adding sections 20-3103 and 20-3104, to read:

20-3103. Denial of health care services claim; required information

A. IF A HEALTH CARE INSURER DENIES A HEALTH CARE SERVICES CLAIM, IN WHOLE OR IN PART, THE HEALTH CARE INSURER SHALL PROVIDE THE HEALTH CARE PROVIDER AT THE TIME OF THE DENIAL WITH 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.

B. AT THE REQUEST OF THE HEALTH CARE PROVIDER, A HEALTH CARE INSURER SHALL PROVIDE THE FOLLOWING INFORMATION TO THE HEALTH CARE PROVIDER WITHIN FIFTEEN DAYS AFTER RECEIVING THE REQUEST:

1. IF A 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 PURSUANT TO SECTION 20-2533.

2. A HEALTH CARE PROVIDER'S RIGHT TO DISPUTE THE HEALTH CARE INSURER'S DECISION THAT INCLUDES THE FOLLOWING:

(a) THE MANNER IN WHICH THE HEALTH CARE PROVIDER MAY DISPUTE THE HEALTH CARE INSURER'S DECISION USING THE HEALTH CARE INSURER'S INTERNAL GRIEVANCE PROCESS, INCLUDING APPLICABLE DEADLINES PRESCRIBED IN SECTION 20-3102.

(b) THE HEALTH CARE PROVIDER'S RIGHT TO REQUEST A HEARING PURSUANT TO SECTION 20-3104, IF THE INTERNAL GRIEVANCE PROCESS WITH THE HEALTH CARE INSURER IS UNRESOLVED, INCLUDING THE MANNER IN WHICH THE HEALTH CARE PROVIDER MAY REQUEST A HEARING PURSUANT TO SECTION 20-3104.

3. IF THE HEALTH CARE PLAN IS NOT SUBJECT TO REGULATION BY THE DEPARTMENT, A NOTIFICATION TO THE HEALTH CARE PROVIDER OF THE APPROPRIATE REGULATORY AUTHORITY.

C. WITHIN THIRTY DAYS AFTER RECEIVING A WRITTEN GRIEVANCE PURSUANT TO SECTION 20-3102, THE HEALTH CARE INSURER SHALL RESPOND IN WRITING WITH THE HEALTH CARE INSURER'S DECISION, UNLESS THE HEALTH CARE PROVIDER AND THE HEALTH CARE INSURER MUTUALLY AGREE TO A LONGER PERIOD OF TIME.

D. THE HEALTH CARE INSURER'S DECISION REGARDING THE GRIEVANCE SHALL INCLUDE:

1. THE DATE OF THE DECISION.

2. THE FACTUAL AND LEGAL BASIS FOR THE DECISION.

3. THE HEALTH CARE PROVIDER'S RIGHT TO REQUEST A HEARING.

4. THE MANNER IN WHICH A HEALTH CARE PROVIDER MAY REQUEST A HEARING.

E. IF A HEALTH CARE INSURER FINDS IN FAVOR OF THE HEALTH CARE PROVIDER, IN WHOLE OR IN PART, A HEALTH CARE INSURER SHALL REMIT PAYMENT FOR THE APPROVED PORTION OF THE CLAIM WITHIN FIFTEEN DAYS AFTER THE DATE OF THE HEALTH CARE INSURER'S DECISION.

20-3104. Health care provider claim dispute; hearing

A. IF A HEALTH CARE PROVIDER'S GRIEVANCE IS UNRESOLVED PURSUANT TO SECTION 20-3103, IN WHOLE OR IN PART, THE HEALTH CARE PROVIDER MAY SUBMIT A WRITTEN REQUEST FOR A HEARING TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE HEALTH CARE INSURER'S DECISION OR THE DATE ON WHICH THE HEALTH CARE PROVIDER SHOULD HAVE RECEIVED THE HEALTH CARE INSURER'S DECISION AND SHALL SUBMIT A COPY OF THE HEARING REQUEST TO THE HEALTH CARE INSURER.

B. IF THE HEALTH CARE PROVIDER TIMELY SUBMITS A REQUEST FOR A HEARING WITH THE DEPARTMENT, THE DEPARTMENT SHALL REQUEST A HEARING WITHIN THE OFFICE OF ADMINISTRATIVE HEARINGS PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

C. IF THE HEALTH CARE PROVIDER DECIDES TO WITHDRAW THE HEALTH CARE PROVIDER'S REQUEST FOR A HEARING, THE HEALTH CARE PROVIDER SHALL SEND A WRITTEN REQUEST FOR WITHDRAWAL TO THE DEPARTMENT. THE DEPARTMENT SHALL ACCEPT THE WRITTEN REQUEST FOR WITHDRAWAL IF THE WRITTEN REQUEST FOR WITHDRAWAL IS RECEIVED BEFORE THE DEPARTMENT REQUESTS A HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10. IF THE DEPARTMENT ALREADY SUBMITTED A REQUEST FOR A HEARING, THE HEALTH CARE PROVIDER SHALL PROMPTLY SEND A WRITTEN REQUEST FOR WITHDRAWAL TO THE OFFICE OF ADMINISTRATIVE HEARINGS.

D. NOTWITHSTANDING SECTION 12-908 AND TITLE 41, CHAPTER 6, ARTICLE 10, IF A PARTY TO A DECISION ISSUED UNDER THIS SECTION SEEKS FURTHER ADMINISTRATIVE REVIEW, THE DEPARTMENT SHALL NOT BE A PARTY TO THE ACTION UNLESS THE DEPARTMENT FILES A MOTION TO INTERVENE IN THE ACTION.

Sec. 4. Section 20-3451, Arizona Revised Statutes, is amended to read:

20-3451. Definitions

In this chapter, unless the context otherwise requires:

1. "Applicant" means a provider that submits a credentialing application to a health insurer to become a participating provider in the health insurer's network.

2. "Application" means an applicant's initial application to be credentialed as a participating provider.

3. "COMPLETE CREDENTIALING APPLICATION" MEANS SUBMISSION OF A HEALTH PLAN'S CREDENTIALING APPLICATION, INCLUDING ANY REQUIRED SUPPORTING DOCUMENTATION.

~~3.~~ 4. "Credentialing" means to collect, verify and assess whether a provider meets relevant licensing, education and training requirements to become or remain a participating provider.

~~4.~~ 5. "Designee" means a third party to whom the health insurer has delegated credentialing activities or responsibilities.

~~5.~~ 6. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or ~~a~~ hospital, medical, dental and optometric service corporation and includes the health insurer's designee. Health insurer does not include a pharmacy benefits manager as defined in section 20-3321.

~~6.~~ 7. "Loading" means to input a participating provider's information into a health insurer's billing system for the purpose of processing claims and submitting reimbursement for covered services.

~~7.~~ 8. "Participating provider" means a provider that has been credentialed by a health insurer ~~or its designee~~ to provide health care items or services to subscribers in at least one of the health insurer's provider networks.

~~8.~~ 9. "Provider" means a physician, hospital or other person that is licensed in this state or that is otherwise authorized to furnish health care services in this state.

~~9.~~ 10. "~~Recredentialing~~ RECREDENTIAL" means to confirm that a participating provider is in good standing by a health insurer ~~or its designee~~ and does not require submitting an application or going through a contracting and loading process.

~~10.~~ 11. "Subscriber" means a person who is eligible to receive health care benefits pursuant to a health insurance policy or coverage issued or provided by a health insurer.

Sec. 5. Section 20-3453, Arizona Revised Statutes, is amended to read:

20-3453. Credentialing; loading; timelines; exception

A. Except as provided in subsection C of this section, the health insurer shall conclude the process of credentialing and loading the applicant's information into the health insurer's billing system within ~~one hundred~~ FORTY-FIVE calendar days after the date the health insurer receives a complete CREDENTIALING application.

B. A HEALTH INSURER SHALL PROVIDE WRITTEN OR ELECTRONIC CONFIRMATION:

1. WITHIN TWO BUSINESS DAYS ON RECEIPT OF A COMPLETE CREDENTIALING APPLICATION.

2. WITHIN SEVEN BUSINESS DAYS ON RECEIPT OF A CREDENTIALING APPLICATION WITH DEFICIENCIES.

~~B.~~ C. A health insurer shall provide written or electronic notice of the approval or denial of a COMPLETE credentialing application to an

applicant within seven calendar days after the conclusion of the credentialing process.

~~C.~~ D. If a licensed health care facility has a delegated credentialing agreement with a health insurer, the health insurer is not responsible for compliance with the timeline prescribed in subsection A of this section for an applicant who works for that facility, but shall conclude the loading process for that applicant within ten calendar days after the health insurer receives a roster of demographic changes related to newly credentialed, terminated or suspended participating providers.

Sec. 6. Section 20-3456, Arizona Revised Statutes, is amended to read:

20-3456. Covered services; claims

A health insurer ~~may not deny~~ SHALL 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 ~~if the covered services are provided after the date of approval of the credentialing application.~~ AND WHOSE CREDENTIALING APPLICATION HAS BEEN APPROVED BY THE HEALTH INSURER RETROACTIVELY TO THE DATE OF THE PARTICIPATING PROVIDER'S COMPLETE CREDENTIALING APPLICATION.