

House Engrossed

insurance; claims; appeals; provider credentialing

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

HOUSE BILL 2035

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)

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Section 20-3101, Arizona Revised Statutes, is amended to
3 read:
4 20-3101. Definitions
5 In this article, unless the context otherwise requires:
6 1. "Adjudicate" means an insurer's decision to deny or pay a claim,
7 in whole or in part, including the decision as to how much to pay.
8 2. "Clean claim" means a written or electronic claim for health
9 care services or benefits that may be processed without obtaining
10 additional information, including coordination of benefits information,
11 from the health care provider, the enrollee or a third party, except in
12 cases of fraud.
13 3. "Enrollee" means an individual who is enrolled under a health
14 care insurer's policy, contract or evidence of coverage.
15 4. "Grievance" means any written complaint that is subject to
16 resolution through the insurer's system that is prescribed in section
17 20-3102, subsection F and submitted by a health care provider and received
18 by a health care insurer. Grievance does not include a complaint:
19 (a) By a noncontracted provider regarding an insurer's decision to
20 deny the noncontracted provider admission to the insurer's network.
21 (b) About an insurer's decision to terminate a health care provider
22 from the insurer's network.
23 (c) That is the subject of a health care appeal pursuant to chapter
24 15, article 2 of this title.
25 5. "HEALTH CARE FACILITY" MEANS A HOSPITAL, OUTPATIENT SURGICAL
26 CENTER, HEALTH CARE LABORATORY, DIAGNOSTIC IMAGING CENTER OR URGENT CARE
27 CENTER.
28 ~~5.~~ 6. "Health care insurer" means a disability insurer, group
29 disability insurer, blanket disability insurer, health care services
30 organization, prepaid dental plan organization, hospital service
31 corporation, medical service corporation, dental service corporation,
32 optometric service corporation, or hospital, medical, dental and
33 optometric service corporation."
34 7. "HEALTH CARE PLAN":
35 (a) MEANS A PLAN OFFERED BY A DISABILITY INSURER, GROUP DISABILITY
36 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,
37 HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION THAT
38 CONTRACTUALLY AGREES TO PAY OR MAKE REIMBURSEMENT FOR HEALTH CARE EXPENSES
39 FOR ONE OR MORE INDIVIDUALS WHO RESIDE IN THIS STATE.
40 (b) DOES NOT INCLUDE LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION
41 20-1137.
42 8. "HEALTH CARE PROVIDER" MEANS:
43 (a) A PERSON WHO IS LICENSED, REGISTERED OR CERTIFIED AS A HEALTH
44 CARE PROFESSIONAL PURSUANT TO TITLE 32.

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

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

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

7 20-3102. Timely payment of health care providers' claims;
8 grievances

9 A. A health care insurer shall adjudicate any clean claim from a
10 contracted or noncontracted health care provider relating to health care
11 insurance coverage within thirty days after the health care insurer
12 receives the clean claim or within the time period specified by contract.
13 Unless there is an express written contract between the health care
14 insurer and the health care provider that specifies the period in which
15 approved claims shall be paid, the health care insurer shall pay the
16 approved portion of any clean claim within thirty days after the claim is
17 adjudicated. If the claim is not paid within the thirty-day period or
18 within the time period specified in the contract, the health care insurer
19 shall pay interest on the claim at a rate that is equal to the legal rate.
20 Interest shall be calculated beginning on the date that the payment to the
21 health care provider is due.

22 B. If the claim is not a clean claim and the health care insurer
23 requires additional information to adjudicate the claim, the health care
24 insurer shall send a written request for additional information to the
25 contracted or noncontracted health care provider, enrollee or third party
26 within thirty days after the health care insurer receives the claim. The
27 health care insurer shall notify the contracted or noncontracted health
28 care provider of all of the specific reasons for the delay in adjudicating
29 the claim. The health care insurer shall record the date it receives the
30 additional information and shall adjudicate the claim within thirty days
31 after receiving all the additional information. The health care insurer
32 shall also pay the approved portion of the adjudicated claim within the
33 same thirty-day period allowed for adjudication or within the time period
34 specified in the provider's contract. If the health care insurer fails to
35 pay the claim as prescribed in this subsection, the health care insurer
36 shall pay interest on the claim in the manner prescribed in subsection A
37 OF THIS SECTION.

38 C. A health care insurer shall not delay the payment of clean
39 claims to a contracted or noncontracted provider or pay less than the
40 amount agreed to by contract to a contracted health care provider without
41 reasonable justification.

42 D. A health care insurer shall not request information from a
43 contracted or noncontracted health care provider that does not apply to
44 the medical condition at issue for the purposes of adjudicating a clean
45 claim.

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

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

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

19 2. The type of grievance.

20 3. The date the insurer received the grievance.

21 4. The date the grievance was resolved.

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

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

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

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

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

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

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

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

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

10 20-3103. Denial of health care services claim: required
11 information

12 A. IF A HEALTH CARE INSURER DENIES A HEALTH CARE SERVICES CLAIM, IN
13 WHOLE OR IN PART, THE HEALTH CARE INSURER SHALL PROVIDE THE HEALTH CARE
14 PROVIDER AT THE TIME OF THE DENIAL WITH CONTACT INFORMATION THAT INCLUDES
15 A TELEPHONE NUMBER AND AN EMAIL ADDRESS FOR AN INDIVIDUAL WHO IS ABLE TO
16 RESPOND TO QUESTIONS ABOUT THE CLAIM DENIAL.

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

20 1. IF A DENIAL WAS BASED ON LACK OF MEDICAL NECESSITY, A DETAILED
21 REASON WHY THE HEALTH CARE SERVICE WAS NOT MEDICALLY NECESSARY AND THE
22 HEALTH CARE PROVIDER'S RIGHT TO APPEAL PURSUANT TO SECTION 20-2533.

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

25 (a) THE MANNER IN WHICH THE HEALTH CARE PROVIDER MAY DISPUTE THE
26 HEALTH CARE INSURER'S DECISION USING THE HEALTH CARE INSURER'S INTERNAL
27 GRIEVANCE PROCESS, INCLUDING APPLICABLE DEADLINES PRESCRIBED IN SECTION
28 20-3102.

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

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

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

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

- 42 1. THE DATE OF THE DECISION.
43 2. THE FACTUAL AND LEGAL BASIS FOR THE DECISION.

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

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

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

8 20-3104. Health care provider claim dispute; hearing

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

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

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

28 D. NOTWITHSTANDING SECTION 12-908 AND TITLE 41, CHAPTER 6, ARTICLE
29 10, IF A PARTY TO A DECISION ISSUED UNDER THIS SECTION SEEKS FURTHER
30 ADMINISTRATIVE REVIEW, THE DEPARTMENT SHALL NOT BE A PARTY TO THE ACTION
31 UNLESS THE DEPARTMENT FILES A MOTION TO INTERVENE IN THE ACTION.

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

34 20-3451. Definitions

35 In this chapter, unless the context otherwise requires:

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

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

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

1 ~~3.~~ 4. "Credentialing" means to collect, verify and assess whether
2 a provider meets relevant licensing, education and training requirements
3 to become or remain a participating provider.

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

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

12 ~~6.~~ 7. "Loading" means to input a participating provider's
13 information into a health insurer's billing system for the purpose of
14 processing claims and submitting reimbursement for covered services.

15 ~~7.~~ 8. "Participating provider" means a provider that has been
16 credentialed by a health insurer ~~or its designee~~ to provide health care
17 items or services to subscribers in at least one of the health insurer's
18 provider networks.

19 ~~8.~~ 9. "Provider" means a physician, hospital or other person that
20 is licensed in this state or that is otherwise authorized to furnish
21 health care services in this state.

22 ~~9.~~ 10. "~~Recredentialing~~ **RECREREDENTIAL**" means to confirm that a
23 participating provider is in good standing by a health insurer ~~or its~~
24 ~~designee~~ and does not require submitting an application or going through a
25 contracting and loading process.

26 ~~10.~~ 11. "Subscriber" means a person who is eligible to receive
27 health care benefits pursuant to a health insurance policy or coverage
28 issued or provided by a health insurer.

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

31 20-3453. Credentialing; loading; timelines; exception

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

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

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

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

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

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

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

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

12 20-3456. Covered services; claims

13 A health insurer ~~may not deny~~ SHALL PAY a claim for a covered
14 service provided to a subscriber by a participating provider who has a
15 fully executed contract with a network plan ~~if the covered services are~~
16 ~~provided after the date of approval of the credentialing application.~~ AND
17 WHOSE CREDENTIALING APPLICATION HAS BEEN APPROVED BY THE HEALTH INSURER
18 RETROACTIVELY TO THE DATE OF THE PARTICIPATING PROVIDER'S COMPLETE
19 CREDENTIALING APPLICATION.