GRIEVANCE AND APPEAL SYSTEM REPORTING GUIDE

Effective: October 1, 2026[1]

[1] Reporting using this version of the Grievance and Appeal System Reporting Guide shall begin with October 2026 data.

TABLE OF CONTENTS

Purpose

The AHCCCS Grievance and Appeal System Reporting Guide (Guide) applies to ACC, ACC-RBHA, ALTCS/EPD, DCS/CHP (CHP), and DES DDD (DDD) Contractors. The purpose of the Guide is to provide instructions to Contractors on how to complete the Grievance and Appeal System Report for submission to and review by AHCCCS, as required by contract.

DES DDD must report Long Term Care data directly as well as separate reports received from its Subcontracted Health Plans. DCS CHP reports data received from its Subcontracted Health Plan.

ACC-RBHA Contractors must submit a Grievance and Appeal System report for each population [one for RBHA-served population (i.e., SMI) and one for ACC-served populations (i.e., Child, Adult, GMH/SU)].

Definitions

For purposes of this Guide:

STANDARD AUTHORIZATION REQUEST	A request for a service that is not a medication, and which does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the Contractor receives the request is considered the date of receipt and is used to determine the due date for completion of the decision. For standard authorization decisions (those not involving medications), the Contractor shall provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than seven calendar days following the receipt of the authorization request, regardless of whether the 7th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 additional calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's best interest [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(1)(i)-(ii), 42 CFR 438.404(c)(3)-(4)].
EXPEDITED SERVICE AUTHORIZATION REQUEST	A request for a service that is not a medication in which either the requesting provider indicates, or the Contractor determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. For expedited authorization decisions (those not involving medications), the Contractor shall provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 72 hours following the receipt of the authorization request, regardless of whether the 72 hour deadline falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's interest [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(2)(i)-(ii), 42 CFR 438.404(c)(6)].

SERVICE AUTHORIZATION REQUEST FOR MEDICATIONS	For service authorization decisions for medications, the Contractor shall provide a Notice of Adverse Benefit Determination no later than 24 hours from receipt to the provider and member of the authorization request regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona [42 CFR 438.210(d)(3), 42 CFR 457.1230(d), and SSA 1927(d)(5)(A)]. If the prior authorization request for the medication lacks sufficient information for the Contractor to render a decision for the medication, the Contractor shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request. The Contractor shall provide the Notice of Adverse Benefit Determination no later than seven business days from the initial date of the authorization request [42 CFR 438.3(s)].
DATE OF DECISION (DOD)	For Authorization Requests the date that the Contractor makes and communicates the decision to the member and/or his/her designated representative.
DATE OF PROCESSING (DOP)	Date that the appeal, claim or claim dispute decision is communicated by the Contractor.
DATE OF RECEIPT (DOR)	Date that the grievance, service authorization request, appeal, claim or claim dispute is received by the Contractor.
INCORRECT HANDLING	Error in the Contractor's claims process that led to a denial, partial denial or inaccurate payment of a claim that resulted in a claim dispute request. (Examples include, but are not limited to: provider contract loading delay; provider contract loading error; paid at the wrong rate; fee schedule not updated; improper or incorrect denial reason; EOB was overlooked, secondary review as defined below).
INDEPENDENT REVIEW ENTITY (IRE)	An independent entity contracted by the Centers for Medicare and Medicaid Services (CMS) to review Medicare health plans' adverse reconsiderations of organizational determinations.
NOTICE OF APPEAL RESOLUTION	The written notice to the member and/or his/her designated representative regarding the final determination of an appealed action. The contents of a Notice of Appeal Resolution are strictly defined in Contract, Rule, and Policy.
NOTICE OF DECISION	The written notice sent to the provider regarding the final determination of a disputed claim payment or claim denial. The contents of a Notice of Decision are strictly defined in Contract, Rule, and Policy.

OVERTURNED	The original decision of the Contractor is determined incorrect or incomplete and is reversed. This category is further divided into those disputes that are reversed due to Contractor error in processing (overturned due to incorrect handling and those that are reversed due to additional information being submitted by the member or provider which provides the grounds for the reversal (overturned due to additional information submitted).
PARTIALLY OVERTURNED	The original decision of the Contractor was reversed, but the outcome is not entirely in the member and/or provider's favor. This category is further divided into those disputes that are reversed due to Contractor error in processing (partially overturned due to incorrect handling and those that are reversed due to additional information being submitted by the member or provider which provide the grounds for the reversal (partially overturned due to additional information submitted).
SECONDARY REVIEW	An evaluation conducted by another medical professional to confirm the accuracy of an initial determination.
STATE FAIR HEARING	An administrative hearing under ARS Title 41, Chapter 6, Article 10.
TURN AROUND TIME (TAT)	The time from the date of receipt to the date of decision.
UPHELD	The original determination of the Contractor is maintained.

Additional definitions are located on the AHCCCS website at: AHCCCS ACOM and AMPM Dictionary.

Grievance and Appeal System Report

The Contractor must adhere to all requirements specified in contract (Attachment F1, Member Grievance and Appeal System Standards, F2, Provider Claim Dispute Standards, and the Grievance and Appeal System paragraph) and ACOM Policy 414, related to appeals, grievances, provider disputes, and requests for hearing.

The Contractor is required to utilize the Grievance and Appeal System Reporting Template, which includes Attachments A through G of this Guide, for submittal of the Grievance and Appeal System Report. The Grievance and Appeal System Report shall be submitted as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

Data is only required to be submitted in Attachment F and G with the final submission of the Report for the Contract Year.

The Contractor must submit a corrected report if data in a previous report is changed, resubmitted reports may be required for each month that may need a correction as directed by AHCCCS. Submission of corrected data must be clearly indicated in the submitted respective Cover Letter and Report (e.g., with footnote and/or highlight yellow).

The Contractor shall include any data from a delegated entity in its Grievance and Appeal System Report submission on the appropriate tab.

All questions regarding the reporting requirements must be directed to the Contractor's designated AHCCCS Operations Compliance Officer (OCO).

The Grievance and Appeal System Report includes:

- Cover Letter (Cover Letter Template),
- Attachment A, Provider Claim Disputes,
- Attachment B1, Admissions and Prior Authorizations Report (Medical/Surgical Inpatient, Medical/Surgical Outpatient, and All Prescription Drugs; excluding Behavioral Health),
- Attachment B2, Behavioral Health Admissions and Prior Authorizations Report (Behavioral Health Inpatient and Outpatient; excluding Medical/Surgical and All Prescription Drugs),
- Attachment C, Appeal and Hearing Requests,
- Attachment D, Monthly Member Grievances Report,
- Attachment E, Resolved Member Grievances Tracking,
- Attachment F, Member Grievances and Appeals Resolved during the Contract Year, and
- Attachment G, Prior Authorization Requests during the Contract Year

The Contractor must submit a corrected Report if data in a previous report is changed.

Cover Letter & Template

The Contractor must submit the Grievance and Appeal System Report with an accompanying cover letter that summarizes the data, including a trend analysis of month-to-month performance changes and explain the factors contributing to significant fluctuations in either direction (positive or negative), and explains any interventions implemented as a result of identified issues for each Attachment. The cover letter shall be submitted using the Cover Letter Template. Refer to the AHCCCS Grievance and Appeal System Reporting Guide Web page for the Cover Letter Template.

The Contractor shall provide an explanation in the cover letter if there is a fluctuation of 10% or more in either direction (positive or negative) in data reported, from the previous reporting period.

Grievance and Appeal System Reporting & Template

The Contractor must submit the Grievance and Appeal System Report using the Grievance and Appeal System Reporting Template. Refer to the AHCCCS Grievance and Appeal System Reporting Guide Web Page for Reporting Template Attachments A through G.

Grievances and appeals are to be counted as received only when a valid member consent is received and on file.

Attachment A: Provider Claim Dispute Report

Section A. Claim Disputes Summary

The numbers in Section A must be reported by age of the claim dispute as determined by Date of Receipt (DOR) through Date of Processing (DOP) and also by total number in the category. For the purposes of recording the accurate number of disputes, each individual claim addressed in a filing equates one dispute, (e.g., a filing where the provider includes ten claims in a single submission would be counted as ten individual claim disputes).

A1. The total number of claim disputes that remained open from the previous reporting period (reported in Row A4) must be carried over to this report. The total must equal the sum of the three categories below.
   I. Ending Inventory from Previous Month ≤ 30 calendar days
   II. Ending Inventory from Previous Month > 30 calendar days and ≤ 45 calendar days
   III. Ending Inventory from Previous Month > 45 calendar days

A2. Total number of claim disputes logged as received during the reporting period.

A3. Total number of claim disputes closed, and decisions issued, during the reporting period.

A4. The total number of claim disputes remaining open from the previous reporting period, added to those received during the current period and subtracting disputes closed during the reporting period (A1 + A2 - A3 = A4). The total must equal the sum of the three categories below.
   I. Current Inventory at End of Month ≤ 30 calendar days
   II. Current Inventory at End of Month > 30 calendar days and ≤ 45 calendar days
   III. Current Inventory at End of Month > 45 calendar days

Section B. Claim Dispute Decisions

The numbers in Section B must be reported as a total number of disputes that can be assigned to the category for decisions issued during the reporting period.

B1. The total number of upheld claim disputes (excluding untimely dispute filings) during the reporting period including those that were opened in previous periods.

B2. The total number of upheld claim disputes received by the Contractor, received later than 12 months after the date of service, later than 12 months after the date that eligibility is posted or later than 60 calendar days after the date of the denial of a timely claim submission.

B3. The total number of overturned claim disputes during the reporting period; including those received in previous periods.
   I. Overturned due to a finding of incorrect handling that with all available information at the time of first review, the claim was inappropriately processed based on medical necessity or administrative criteria.
   II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B4. The total number of partially overturned Claim Disputes during the reporting period, including those received in previous periods.
   I. Partially overturned due to an incorrect handling finding that with all available information at the time of first review, the claim was inappropriately processed based on medical necessity or administrative criteria.
   II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B5. The total number of claim disputes with an agreed upon extension.

B6. The total number of claims forwarded for reprocessing as the result of an overturned or partially overturned, claim dispute.

Section C. Requests for Hearing Summary

The numbers in Section C must be reported by the total number of State Fair Hearing Requests meeting the categorical criteria. The Contractor must report all State Fair Hearing activity occurring during the reporting period, regardless of when the original dispute was received.

C1. The total number of Requests for State Fair Hearing (RFH) received during the reporting period.

C2. The number of RFH forwarded to the AHCCCS Office of General Council (OGC), or other appropriate regulatory agency, within five business days of receipt by the Contractor.

C3. The number of RFH that were forwarded to the AHCCCS OGC, or other appropriate regulatory agency, more than five business days from the date of Contractor receipt.

C4. The total number of cancelled (withdrawn or vacated) RFH.
   I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor
   II. Percentage of RFH cancelled due to Contractor initiated settlement (Formula built in)

C5. The total number of Director's Decisions received during the reporting period that found in favor of the Provider, either in whole or in part.

C6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in C4).

Section D. Dispute Categories - Trending Analysis

The numbers in Section D must be reported as a total number per category and as a percentage of the total number of disputes received for the reporting period (Formula built in). Available categories for completing Section D (not exclusive of new categories as needed and defined in the cover letter) include:

COD (Coding Dispute) – Disputes of a coding nature such as claims containing incorrect HCPCS; CPT; ICD-9 codes; Revenue Codes and/or modifiers.

DSI (Data Source Issues) – Disputes that are in reference to incorrect recognition of contract, provider registration or member enrollment status.

NPA (No Prior Authorization) – Instances where a claim was denied for requiring prior authorization.

NAM (No Authorization Match) – Instances where a claim was denied because the billed charges or length of stay do not correlate to the Contractor's prior authorization records.

CPE (Claim Processing Error) – Disputes that challenge the correctness of information presented on the Remittance Advice (Examples include: processed to incorrect provider, incorrect member, incorrect procedure code, etc.).

TOC (Timeliness of Claim) – Claims that are resubmitted as a challenge to the finding of timeliness of the original claim submission.

TOP (Timeliness of Payment) – Disputes that are filed on claims that have not been adjudicated.

NPC (Not Paid Correctly) – Dispute filed due to a difference in the expected reimbursement and the Contractor's remittance.

D1-D5. List the top five categories of dispute by volume using the listed or separately noted acronym or abbreviation.

Section E. Disputing Providers - Trending Analysis

E1-E5. List the top five providers including:

I. AHCCCS Provider Identification Number,
II. Total number of disputes received from the provider,
III. The percentage of the number of disputes received from the provider divided by the total number of disputes received for the reporting period (Formula built in), and
IV. The dispute category with the largest number of disputes received from the provider in the reporting period.

For purposes of this reporting a physician's group is considered one provider.

[END OF ATTACHMENT A]

Attachment B1: Admissions and Prior Authorizations Report (Medical/Surgical Inpatient, Medical/Surgical Outpatient, and All Prescription Drugs; excluding Behavioral Health)

Section A. Summary of M/S Inpatient Admissions

Reporting for this section must only include **initial** inpatient admissions.

Medical/Surgical (M/S) is inclusive of all admission types (excluding behavioral health).

The numbers in Section A must be reported as the total number of inpatient admissions, including emergent and planned admissions received during the reporting period.

A1. The total number of M/S inpatient admissions received during the reporting period, to contain all categories of inpatient admissions, including emergent, urgent, and planned admissions.

A2. The total number of approved M/S inpatient admissions.

A3. The number of M/S inpatient admissions that were denied (not approved as requested upon initial review or concurrent review and resulted in an Adverse Benefit Determination) [Action], (i.e., limited authorization, denials, suspensions, reductions, or terminations). This number must be reported as the total number of Actions taken during the reporting period by category.

The total number in each of the following categories:

I. Not a Covered Benefit or Exhausted Benefit,
II. Not Medically Necessary,
III. Out of Network Provider,
IV. Not Enough Information to make a Decision within the legally required timeframe, and
V. Coverage by Another Entity (report any cases related to Coordination of Benefits (COB), Third Party Liability (TPL), or other coverage).

The percentage of the number of M/S inpatient admission actions in each category above divided by the total number of actions taken received for the reporting period (Formula built in).

A4. The percentage of M/S inpatient admissions that resulted in an action (Formula built in).

Section B. M/S Inpatient Admission Utilization

Reporting for this section must only include M/S inpatient admissions.

Section B contains a breakdown of the M/S inpatient utilization summarized. The data in this section must be reported by the Total Number of M/S Inpatient Admissions received during the reporting period.

B1. Section B1 contains information on the Average time from M/S inpatient admission notification to MCO-to-MCO review decision, including:
   I. The average time, **in hours**, from M/S inpatient admission notification to the MCO-to-MCO review decision.

B2. Section B2 contains information on the Average length of stay for M/S inpatient admissions:
   I. The average length of stay, **in calendar days**, for the total number of M/S inpatient admissions.

B3. Section B3 contains information on the use of medical necessity criteria:
   I. The total number of M/S inpatient admissions received in the reporting period (equivalent to Attachment B1, Section A, item A1 - Formula built in equal to A1),
   II. The total number of M/S inpatient admission reviews with evidence of medical necessity criteria being utilized, this is a self-report that is subject to ad hoc audits, and
   III. The percentage of M/S inpatient admissions completed utilizing medical necessity criteria (Formula built in).

Section C. Summary of M/S Outpatient Authorization Requests

The numbers in Section C must be reported as the total number of M/S outpatient authorization requests received during the reporting period.

C1. The total number of M/S outpatient authorization requests received during the reporting period, to contain all categories of requests regardless of urgency or assigned priority (e.g., Standard, Expedited, Extended) and regardless of the status of the authorization at the end of the reporting period.

C2. The number of M/S outpatient authorization requests that were denied (not approved as requested and resulted in an Adverse Benefit Determination) [Action] (i.e., limited authorization, denials, suspensions, reductions, or terminations). This number must be reported as the total number of Actions taken during the reporting period by category.

The total number in each of the following categories:
   I. Not a Covered Benefit or Exhausted Benefit,
   II. Not Medically Necessary,
   III. Out of Network Provider,
   IV. Not Enough Information to make a Decision within the legally required timeframe, and
   V. Coverage by Another Entity (report any cases related to Coordination of Benefits (COB), Third Party Liability (TPL), or other coverage).

The percentage of the number of M/S outpatient authorization request actions in each category above divided by the total number of actions taken received for the reporting period (Formula built in).

C3. The percentage of M/S outpatient authorization requests that resulted in an action (Formula built in).

Section D. Types of M/S Outpatient Authorization Requests

Section D contains a breakdown of the M/S outpatient authorization requests summarized in section C. The data in this section must be reported by the Total Number of M/S Outpatient Authorization Requests received during the reporting period, the Total Number of M/S Outpatient Authorization Requests Completed within Timeliness Standard (as outlined in ACOM Policy 414) and the Percentage of M/S Outpatient Authorization Requests Completed Timely (Formula built in).

D1. Section D1 contains information on Standard M/S outpatient authorization requests, including:
- I. The number of standard authorizations requests, as defined in this reporting guide, received in the reporting period,
- II. The number of standard authorization requests completed within the timeliness standard, and
- III. The percentage completed timely (Formula built in).

D2. Section D2 contains information on Standard M/S outpatient authorization requests requiring an extension, including:
- I. The number of standard requests that were extended due to member request or Contractor determination of necessity,
- II. The number of standard requests with extensions that were completed within the timeliness standard, and
- III. The percentage completed timely (Formula built in).

D3. Section D3 contains information on Expedited M/S outpatient authorization requests, including:
- I. The number of expedited requests, as defined in this reporting guide, received in the reporting period,
- II. The number of expedited requests completed within the timeliness standard, and
- III. The percentage completed timely (Formula built in).

D4. Section D4 contains information on Expedited M/S outpatient authorization requests requiring an extension, including:
- I. The number of expedited authorization requests that were extended due to member request or Contractor determination of necessity,
- II. The number of expedited authorization requests with extensions that were completed within the timeliness standard, and
- III. The percentage completed timely (Formula built in).

D5. The number of expedited M/S outpatient authorization requests that were determined not to require expedited review based on medical necessity and were, therefore, handled under the standard process guidelines during the reporting period.

Section E. Summary of All Prescription Drug Authorization Requests

The numbers in Section E must be reported as the total number of all prescription drug (medication) authorization requests received during the reporting period.

E1. The total number of prescription drug authorization requests received during the reporting period, to contain all categories of prior authorization requests regardless of urgency or assigned priority (e.g., Standard, Expedited, Extended) and regardless of the status of the authorization at the end of the reporting period.

E2. The number of prescription drug authorization requests that were denied (not approved as requested and resulted in an Adverse Benefit Determination([Action], (i.e., limited authorization, denials, suspensions, reductions, or terminations). This number must be reported as the total number of Actions taken during the reporting period by category.

The total number in each of the following categories:

I. Not a Covered Benefit or Exhausted Benefit,
II. Not Medically Necessary,
III. Out of Network Provider,
IV. Not Enough Information to make a Decision within the legally required timeframe, and
V. Coverage by Another Entity (report any cases related to Coordination of Benefits (COB), Third Party Liability (TPL), or other coverage).

The percentage of the number of prescription drug authorization request actions in each category above divided by the total number of actions taken received for the reporting period (Formula built in).

E4. The percentage of prescription drug authorization requests that resulted in an action (Formula built in).

Section F. Types of All Prescription Drug Authorization Requests

Section F contains a breakdown of the prescription drug authorization requests summarized in section E. The data in this section must be reported by the total number of prescription drug authorization requests received during the reporting period, the total number of prescription drug authorization requests completed within timeliness standard (as outlined in ACOM Policy 414), and the percentage of prescription drug authorization requests completed timely (Formula built in).

F1. Section F1 contains information on prescription drug authorization requests, including:

I. The number of prescription drug authorizations requests, as defined in this reporting guide, received in the reporting period,
II. The number of prescription drug authorization requests completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

F2. Section F2 contains information on prescription drug authorization requests requiring an extension due to member request, including:

I. The number of prescription drug authorization requests that were extended,
II. The number of prescription drug authorization requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

[END OF ATTACHMENT B1]

Attachment B2: Behavioral Health Admissions and Prior Authorizations Report (Behavioral Health Inpatient and Outpatient; excluding Medical/Surgical and All Prescription Drugs)

Section A. Summary of Behavioral Health Inpatient Admissions

Reporting for this section must only include **initial** inpatient admissions.

Behavioral health is inclusive of all mental health/substance use disorder admission types.

The numbers in Section A must be reported as the total number of behavioral health inpatient admissions, including emergent and planned admissions received during the reporting period.

Behavioral health inpatient admissions are identified based upon the service code on the authorization request, and in accordance with ACOM Policy 110, Mental Health Parity, which defines the Mental Health and Substance Use Disorder (MH/SUD) benefit. All prescription drug authorization requests must be reported in Attachment B1, Sections E and F.

A1. The total number of behavioral health inpatient admissions, received during the reporting period, to contain all categories of prior authorization requests, including emergent, urgent, and planned admissions.

A2. The total number of approved behavioral health inpatient admissions.

A3. The number of behavioral health inpatient admissions that were denied (not approved as requested upon initial or concurrent review and resulted in an Adverse Benefit Determination) [Action], (i.e., limited authorization, denials, suspensions, reductions, or terminations). This number must be reported as the total number of Actions taken during the reporting period by category.

The total number in each of the following categories:

I. Not a Covered Benefit or Exhausted Benefit,
II. Not Medically Necessary,
III. Out of Network Provider,
IV. Not Enough Information to make a Decision within the legally required timeframe, and
V. Coverage by Another Entity (report any cases related to Coordination of Benefits (COB), Third Party Liability (TPL), or other coverage).

The percentage of the number of behavioral health inpatient admission actions in each category above divided by the total number of actions taken received for the reporting period (Formula built in).

A4. The percentage of behavioral health inpatient admissions that resulted in an action (Formula built in).

Section B. Behavioral Health Inpatient Admission Utilization

Reporting for this section must only include behavioral health inpatient admissions.

Section B contains a breakdown of behavioral health inpatient admission utilization. The data in this section must be reported by the total number of behavioral health inpatient admissions received during the reporting period.

B1. Section B1 contains information on the average time from behavioral health inpatient admission notification to MCO-to-MCO review decision, including:
   I. The average time, **in hours**, from behavioral health inpatient admission notification to the MCO-to-MCO review decision.

B2. Section B2 contains information on the average length of stay for behavioral health Inpatient admissions, including:
   I. The average length of stay, **in calendar days**, for the total number of behavioral health inpatient admissions.

B3. Section B3 contains information on the use of medical necessity criteria, including:
   I. The total number of behavioral health inpatient admissions received in the reporting period (equivalent to Attachment B2, Section A, item A1 - Formula built in equal to A1),
   The total number of behavioral health inpatient admission reviews with evidence of medical necessity criteria being utilized, this is a self-report that is subject to ad hoc audits, and
   II. The percentage of behavioral health inpatient admissions completed utilizing medical necessity criteria (Formula built in).

Section C. Summary of Behavioral Health Outpatient Authorization Requests

The numbers in Section C must be reported as the total number of behavioral health outpatient authorization requests received during the reporting period. Behavioral health prior authorization requests are identified based upon the service code on the authorization request, and in accordance with ACOM Policy 110, Mental Health Parity, which defines the Mental Health and Substance Use Disorder (MH/SUD) benefit. All prescription drug authorization requests must be reported in Attachment B1, Sections E and F.

C1. The total number of behavioral health outpatient authorization requests received during the reporting period, to contain all categories of prior authorization requests regardless of urgency or assigned priority (e.g., Standard, Expedited, Extended) and regardless of the status of the authorization at the end of the reporting period.

C2. The number of behavioral health outpatient authorization requests that were denied (not approved as requested and resulted in an Adverse Benefit Determination) [Action], (i.e., limited authorization, denials, suspensions, reductions, or terminations). This number must be reported as the total number of Actions taken during the reporting period by category.

The total number in each of the following categories:

I. Not a Covered Benefit or Exhausted Benefit,
II. Not Medically Necessary,
III. Out of Network Provider,
IV. Not Enough Information to make a Decision within the legally required timeframe, and
V. Coverage by Another Entity (report any cases related to Coordination of Benefits (COB), Third Party Liability (TPL), or other coverage).

The percentage of the number of behavioral health outpatient authorization request actions in each category divided by the total number of actions taken received for the reporting period (Formula built in).

C3. The percentage of behavioral health outpatient authorization requests that resulted in an action (Formula built in).

Section D. Types of Behavioral Health Outpatient Authorization Requests

Section D contains a breakdown of the behavioral health outpatient authorization requests summarized in Section C. The data in this section must be reported by the total number of behavioral health outpatient authorization requests received during the reporting period, the total number of behavioral health outpatient authorization requests completed within timeliness standard (as outlined in ACOM Policy 414) and the percentage of behavioral health outpatient authorization requests completed timely (Formula built in).

D1. Section D1 contains information on standard behavioral health outpatient authorization requests, including:

I. The number of standard authorizations requests, as defined in this reporting guide, received in the reporting period,
II. The number of standard authorization requests completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

D2. Section D2 contains information on standard behavioral health outpatient authorization requests requiring an extension, including:

I. The number of standard requests that were extended due to member request or Contractor determination of necessity,
II. The number of standard requests with extensions that were completed within the timeliness standard, and
III. The percentage completed timely (Formula built in).

D3. Section D3 contains information on expedited behavioral health outpatient authorization requests, including:
   I. The number of expedited requests, as defined in this reporting guide, received in the reporting period,
   II. The number of expedited requests completed within the timeliness standard, and
   III. The percentage completed timely (Formula built in).

D4. Section D4 contains information on expedited behavioral health outpatient authorization requests requiring an extension, including:
   I. The number of expedited authorization requests that were extended due to member request or Contractor determination of necessity,
   II. The number of expedited authorization requests with extensions that were completed within the timeliness standard, and
   III. The percentage completed timely (Formula built in).

D5. The number of expedited behavioral health outpatient authorization requests that were determined not to require expedited review based on medical necessity and were, therefore, handled under the standard process guidelines during the reporting period.

[END OF ATTACHMENT B2]

Attachment C: Appeal and Hearing Request Report

Section A. and B. Standard Appeals

This section contains information regarding Standard Appeals of a Contractor's action, as defined in this guide.

The data in Section A is reported by age of the standard appeal as determined by subtracting the DOR from the last day of the reporting period and the total number of appeals that meet the criteria for standard appeals as defined in this guide.

A1. The number of standard appeals remaining open on the first day of the reporting period, as reported in line A5 of the previous reporting period.

A2. The number of standard appeals received during the reporting period.

A3. The total number of standard appeals closed during the reporting period.

A4. The number of standard appeals closed during the reporting period and that were completed within 30 calendar days.

A5. The total number of standard appeals remaining open at the end of the reporting period. The total must equal the sum of the three categories below.
   I. Current Inventory as of End of reporting period ≤ 30 calendar days
   II. Current Inventory as of End of reporting period > 30 calendar days and ≤ 45 calendar days
   III. Current Inventory as of End of reporting period > 45 calendar days

The data in Section B is reported as a total count of standard appeals closed during the reporting period that fall into each category for appeal resolutions issued during the reporting period.

B1. The total number of upheld standard appeals.

B2. The total number of standard appeals received by the Contractor untimely, or later than 60 calendar days from the date of the NOA.

B3. The total number of standard appeals overturned due to:
   I. A secondary review finding that with all available information at the time of first review, the request was inappropriately processed based on medical necessity or administrative criteria.
   II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B4. The total number of standard appeals partially overturned due to:
   I. A secondary review finding that with all available information at the time of first review, the request was inappropriately processed based on medical necessity or administrative criteria.
   II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B5. The total number of standard appeals requiring an extension.

Section C. Requests for Hearing

The data in Section C is to be reported as a total count of member Requests for State Fair Hearing (RFH) files that meet the criteria listed below by category.

C1. The total number of RFH files received during the reporting period.

C2. The number of RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

C3. The number of RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

C4. The total number of cancelled (withdrawn or vacated) RFH.
   I. Those cancelled (withdrawn or vacated) RFH due to a settlement agreement initiated by the Contractor

C5. The total number of Director's Decisions received during the reporting period that found in favor of the Member either in whole or in part.

C6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in C4).

Section D. and E. Expedited Appeals

This section contains information regarding requests for Expedited Appeals of a Contractor's action, as defined in this guide.

The data in Section D is reported by age of the expedited appeal as determined by subtracting the DOR from the last day of the reporting period and the total number of appeals that meet the criteria for expedited appeals as defined in this guide.

D1. The number of expedited appeals that remained open on the first day of the current reporting period, as reported in line D5 of the previous reporting period.
   I. Expedited appeals from Previous Month > three calendar days

D2. The number of expedited appeals that were received during the reporting period.

D3. The number of expedited appeals that were closed during the reporting period.

D4. The number of expedited appeals closed during the reporting period that were completed within three calendar days.

D5. The number of expedited appeals that remained open on the last day of the reporting period.
   I. Current Inventory as of End of Month > three calendar days

The data in Section E is reported as a total count of expedited appeals closed during the reporting period that fall into each category for appeal resolutions issued during the reporting period.

E1. The total number of upheld expedited appeals.

E2. The total number of expedited appeals received by the Contractor untimely, or later than 60 calendar days from the date of the NOA.

E3. The total number of expedited appeals overturned due to:
   I. A secondary review finding that with all available information at the time of first review, the request was inappropriately processed based on medical necessity or administrative criteria.
   II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

E4. The total number of expedited appeals partially overturned due to:
   I. A secondary review finding that with all available information at the time of first review, the request was inappropriately processed based on medical necessity or administrative criteria.
   II. Additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

E5. The total number of expedited appeals requiring an extension.

E6. The total number of expedited appeal requests that did not meet the criteria for expedited review based on medical necessity and were, therefore, handled under the standard appeal process during the reporting period.

Section F. Requests for Hearing (Expedited)

The data in Section F is to be reported as a total count of Expedited Member State Fair Hearing (RFH) files that meet the criteria listed below by category.

F1. The total number of expedited RFH files received during the reporting period.

F2. The number of expedited RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

F3. The number of expedited RFH that were forwarded to the AHCCCS Office of General Council (OGC) (or appropriate regulatory agency) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request.

F4. The total number of cancelled (withdrawn or vacated) expedited RFH.
I. Those cancelled (withdrawn or vacated) RFH due to a settlement agreement initiated by the Contractor
II. Percentage of RFH cancelled due to Contractor initiated settlement (Formula built in)

F5. The total number of Director's Decisions received during the reporting period that found in favor of the member either in whole or in part (sustained or partially sustained).

F6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in F4).

[END OF ATTACHMENT C]

Attachment D: Monthly Member Grievances Report

The Contractor remains ultimately responsible for adhering to the reporting requirements contained within this guideline for any grievance process, or portion of the grievance process, that has been delegated to a subcontractor through an approved arrangement.

All data reported in columns A through E on the spreadsheet must be listed as outlined below for each sub-category identified:

A. Total Received: The total number of grievances received during the reporting period.

B. Total Resolved: The total number of grievances that were resolved/closed through verbal or written methods based on research and response during the reporting period.

C. Resolved 0-10 Calendar Days: Total number of grievances resolved within 10 calendar days of receipt, during the reporting period.

D. Resolved 11-90 Calendar Days: The total number of grievances resolved in more than 10 calendar days, but within 90 days of receipt, during the reporting period.

E. Resolved >90 Calendar Days: The total number of grievances resolved in more than 90 calendar days from the date of receipt, during the reporting period.

F. Resolved 0-10 **Business** Days: Total number of grievances resolved within 10 **business** days of receipt, during the reporting period.

The Contractor must report member grievances broken down by the categories and subcategories outlined below and in the Grievance and Appeal System Report Template.

Transportation: Complaints made by a member/advocate related to the provision of non-emergent transportation services during the reporting period.

Medical Service Provision: Complaints made by a member/advocate related to the service received from a provider, doctor, pharmacy, or facility during the reporting period. These do not include Access to Care complaints.

Contractor Services: Complaints made by a member/advocate relating to the Contractor's administrative processes or the behavior of Contractor staff during the reporting period.

Access to Care: Complaints received from a member/advocate specifically relating to appointment availability during the reporting period.

[END OF ATTACHMENT D]

Attachment E: Resolved Member Grievance Tracking

All Contractors shall complete Attachment E to report a month-to-month roll-up of member grievance data **resolved**. The data populated in this tab is comprised of data from the summary total of column 'B. Total Resolved' from Attachment D.

[END OF ATTACHMENT E]

Attachment F: Member Grievances and Member Appeals Resolved During the Contract Year

The Contractor will complete Attachment F to report data on member grievances and appeals resolved during the contract year, broken down as outlined below. The totals reported in this tab are comprised of the summary totals of data reported in Attachments C and E.

Data is only required to be populated in this tab with the final Grievance System Report for the Contract Year. This data must reset to zero at the start of each contract year. No values from a previous contract year should carry over.

Service Types Related to Resolved Grievances
The data in this section must be reported as the total number, per category, of member grievances resolved for the reporting period. The Contractor must report grievance data broken down by the subcategories outlined in the Grievance and Appeal System Report Template. Therapies includes therapies related to speech language pathology services or occupational, physical, or respiratory therapy services.

Reasons for Resolved Appeals

The data in this section must be reported as a total number, per category, of all member appeals resolved for the reporting period. The Contractor must report appeals data broken down by the subcategories outlined in the Grievance and Appeal System Report Template.

Service Types Related to Resolved Appeals

The data in this section must be reported as a total number, per category, of member appeals resolved for the reporting period. The Contractor must report appeals data broken down by the subcategories outlined in the Grievance and Appeal System Report Template. Therapies includes therapies related to speech language pathology services or occupational, physical, or respiratory therapy services.

[END OF ATTACHMENT F]

Attachment G: Prior Authorization Requests During the Contract Year

The Contractor will complete Attachment G to report data on all prior authorization requests completed during the contract year, including M/S and behavioral health requests. The totals reported in this tab are comprised of the summary totals of data reported in Attachments B1 and B2.

Data is only required to be populated in this tab with the final Grievance System Report for the Contract Year. This data must reset to zero at the start of each contract year. No values from a previous contract year should carry over.

Section A. Standard Prior Authorization Requests

The numbers in Section A must be reported on all Standard Prior Authorizations requests completed by the plan during the contract year.

Section B. Expedited Prior Authorization Requests

The numbers in Section B must be reported on all Expedited Prior Authorizations requests completed by the plan during the contract year.

Section C. Standard and Expedited Prior Authorization Requests

The numbers in Section C must be reported on all Standard and Expedited Prior Authorizations requests completed by the plan during the contract year.

[END OF ATTACHMENT G]