

PIMA HEALTH CARE SYSTEM  
STANDARD AND PROCEDURE

SUBJECT: Provider Claim Dispute	Admin
APPLICABLE TO: Acute Care, Long Term Care Members	Grievance System
EFFECTIVE DATE: 06/09      APPROVED BY: <i>Patricia Alvarez Hurley by signature</i>	GA-II 001
SUPERSEDES: 10/98, 7/99, 10/99, 10/00, 1/16/02 (Provider Grievance and Request for Hearing), 12/1/03, 5/18/04 (Provider Grievance and Appeal of Action); 06/04 Provider Claim Dispute; 05/07, 10/04, 09/05, 04/08, 06/24/09	

I. STATEMENT OF PURPOSE:

This Standard and Procedure establishes a process for providers to request an administrative review by Pima Health System (PHS) in matters challenging a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Statutory Basis: AHCCCS Administrative Code<sup>1</sup> and policies; Arizona Revised Statutes ARS 36-2904; and ARS 36-2903.01.

II. DEFINITIONS:

Claim dispute means a dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance. A claim dispute specifies the factual and legal basis for the claim dispute and the relief requested.

Day means calendar day unless otherwise specified in the text.<sup>2</sup>

Director's Decision means the final administrative decision by the Director of the Arizona Health Care Cost Containment System Administration or designee under A.R.S. § 41-1092(5).

Filed means the date that the request is received as established by the date stamp on the written document or other record of receipt.

Grievance means a complaint initiated by the provider that does not involve a claim dispute.

Grievance Department: The PHS department responsible for managing Provider Claim Disputes, Member Appeals, Member Grievances, and Requests for State Fair Hearing.

Notice of Decision means a written statement of the intended action taken by PHS. The written notice states the factual and legal basis for the action.

<sup>1</sup> In accordance with Arizona Administrative Code Chapter 34, Article 4 Claim Dispute.

<sup>2</sup> As defined by AHCCCSA. Computation of time for calendar day begins the day after the act, event, or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. Working day begins the day after the act, event or decision and includes all working days (Monday through Friday except for those days that fall on an observed holiday).

State Fair Hearing means an administrative hearing under A.R.S. Title 41, Chapter 6, Article 10.

Timeliness of Filing Appeal and Request for Hearing is the period that begins the day after the act, event, or decision grieved or appealed and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or legal holiday.

### III. STANDARDS:

- A. PHS produces and distributes printed information with regards to the claim dispute process to each provider at time of contract in accordance with PHS Standard and Procedure: Provider Manual, PS-I-0012 and PHS Standard and Procedure: Provider Education, PS I-0008.
- B. PHS provides information with regard to the claim dispute process to each non-contracted provider and contracted provider with the Remittance Advice.
  - 1. The Remittance Advice is mailed within 45 days of receipt of a claim.
  - 2. The Remittance Advice includes:
    - a. The reason for the denial;
    - b. Instruction how to submit a “Re-submittal” if needed;
    - c. How to file a written claim dispute; and
    - d. How to request a copy of the PHS Provider Manual.
- C. A claim dispute challenging claim denial must be filed in writing with PHS no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the date of the denial of a timely claim submission, whichever is later.<sup>3</sup>
- D. A claim dispute must state the factual and legal basis for the reason of the appeal and the relief requested.<sup>4</sup>
- E. A claim dispute other than a challenge to a claim payment or claim denial must be filed in writing with PHS no later than 60 days from the date of the action.
- F. In the absence of a contract that specifies otherwise, PHS shall pay interest for all non-hospital claims in accordance with the ACOM 203-AHCCCS Contractors Operations Manual<sup>5</sup>, or for hospital claims, a slow payment penalty in accordance with R9-22-712(C), on all claims that were denied in error. Interest shall not be applied to claim denials that were reversed as an exception.

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<sup>3</sup> ARS 36-2903.01(B)(4)

<sup>4</sup> AAC R9-34-404

<sup>5</sup> ACOM- 203-CONTRACTOR CLAIMS PROCESSING BY SUBCONTRACTED PROVIDERS

In the absence of a contract specifying other late payment terms, Contractors are required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim. In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of 10 percent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid.

- G. A provider may file a written request for a State Fair Hearing no later than 30 days after the date the provider receives PHS' written Notice of Our Decision, or within 30 days after the Notice of Our Decision should have been mailed, if PHS failed to issue the Notice of Our Decision within the required timeframe.
- H. Reinsurance claim disputes are filed directly with AHCCCS as required in A.R.S. 36-2903.01(B)(4) and in accordance with R9-34-406.
- I. Quality of care, medical mismanagement, and potential fraud and abuse concerns are referred to the PHS Quality Management Division in accordance with PHS Quality Management Standards and Procedure: Reporting and Processing Member Concerns, QM III-A.
- J. PHS' Grievance & Appeals Department maintains a log for claim disputes filed that contains the identity of the provider, date of receipt, a brief statement of the nature of the issue, and the date the claim dispute is resolved.
- K. PHS does not discriminate against based on race, color, creed, religion, ancestry, marital status, sexual preference, national origin, limited English proficiency, age, sex, or physical or mental disability, in accordance with Title VI of the U.S. Civil Rights Act of 1964.
- L. Records Maintenance and Release of Safeguarded Information:
  - 1. Provider files, which include all notices, forms, and documents pertaining to a claim dispute, or a request for State Fair Hearing, are maintained and kept in a secure, designated file cabinet by the Grievance Department for one year. At the end of the first year, the files are transferred to Pima County Archives for a period of five years.
  - 2. All files contain, in ascending dated order:
    - a. The initial request;
    - b. Notices sent or received;
    - c. Supporting documents;
    - d. Certified mail receipts.
  - 3. Provider files are stored alphabetically by member's name or provider name (if the provider file contains multiple claim disputes) separated by program (long-term care or acute care).
  - 4. Member information used in the claim dispute or hearing process is safeguarded and released only as provided by law.

#### IV. PROCEDURES:

##### A. Provider Notification by PHS:

- 1. The PHS Provider Remittance Advice is sent to the contracted provider in accordance with PHS Standard and Procedure: Claims Processing Protocols, CL-II-0002.

**B. Claim Dispute Filed with PHS:**

1. Upon initial receipt of a request to file a claim dispute, the Office Support Staff reviews the claim dispute to verify:
  - a. PHS was a party in the claim denial.<sup>6</sup>
  - b. The timeliness of the filing of the dispute, in accordance with Standard C; and
  - c. The documentation submitted with the claim dispute details the factual and legal basis for filing a claim dispute and relief requested.
  
2. If the claim dispute does not meet these criteria, the Office Support Staff notifies the provider in writing that the dispute cannot be accepted on the basis of the specific reasons applicable, as described in Standards C and D.
  
3. If the claim dispute does not qualify as a claim dispute, but does qualify as a Claim Resubmission or is an initial claim submission, the Office Support Staff shall forward the claim and corresponding documentation to the Claims Department for processing. The provider may be notified and provided with information about the Claim Dispute process in writing.
  
4. Upon receipt of a valid claim dispute, the Office Support Staff:
  - a. Date stamps the written request and all accompanying documentation received from the provider;
  - b. Assigns a number to the claim dispute for identification and reporting purposes. The coding scheme for a provider claim dispute is as follows:  
Example: P-00-A-101900-01  
P = Provider  
00 = Contract year  
A = Program (A = Acute; L = LTC)  
101900 = Month, day, year received  
01 = The number in the order the claim dispute was received for the date
  - c. Enters information regarding the claim dispute into the Provider Claim Dispute Log by plan type:
    - 1.) Assigns the claim dispute to an Appeal Specialist
    - 2.) Enters sufficient information regarding the type of dispute, including, but not limited to:
      - a.) The provider's name;
      - b.) The member's name and AHCCCS Identification number;
      - c.) Date received;
      - d.) Date acknowledgement letter was sent to the provider;
      - e.) Reason for the dispute;
      - f.) Outcome and Date of outcome.
  - d. Updates the log as necessary.
  - e. Creates a provider file containing all written information received from the provider regarding the dispute, the worksheet, and any additional documents pertaining to the investigation of the claim dispute.

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<sup>6</sup> A claim dispute is limited to those claims that were submitted to PHS, processed and denied through a remittance advice.

- f. Notifies the provider, in writing, by sending the Acknowledgement of Receipt of Claim Dispute (EXHIBIT A) within five working days of receipt of the provider's request.
- g. Forwards the Claim Dispute to the assigned Appeals Specialist for resolution.

C. Investigation and Decision to Claim Dispute:

1. The Appeals Specialist, under the direction of the Grievance & Appeals Manager:
  - a. Thoroughly investigates the claim dispute issue using applicable statutory, regulatory and contractual provisions; PHS standards and procedures; and collects all facts from all parties pertinent to the dispute.
  - b. Refers all medical issues to the medical claims review nurse for review and recommendation or to a PHS Medical Director in accordance with PHS Utilization Management Standard and Procedure: Chief Medical Officer's Role in Medical Management, CM-MM III-001.<sup>7</sup>
2. After a thorough investigation into the matter using statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties, the Appeals Specialist issues the final decision of the claim dispute no later than 30 days after the filing of the claim dispute unless the provider and PHS agree to a longer period.
3. If the decision to the claim dispute cannot be made within the 30-day timeframe, the Appeals Specialist requests an extension from the provider by mailing the Request For Extension letter (EXHIBIT C) to the provider.
4. The Appeals Specialist:
  - a. Informs the provider in writing of the PHS decision with the Notice of Our Decision (EXHIBIT B).
  - b. Sends the Notice of Our Decision by regular mail to the provider and all parties, unless the decision is adverse to the provider.<sup>8</sup>
  - c. Sends a copy of the Notice of Our Decision to other parties as identified by the provider by regular mail.
  - d. Provides the following information in the Notice of Our Decision:
    - 1.) The nature of the dispute and issue involved;
    - 2.) The date of the decision;
    - 3.) The reason supporting the PHS decision and the factual and legal basis for the decision;
    - 4.) The provider's right to request a State Fair Hearing under ARS 41-1092 et seq. if the decision was adverse to the provider together with the date to file the request for a State Fair Hearing and the manner in which a request for hearing may be filed.
  - e. Updates the provider file to include the all information obtained.
  - f. Returns the provider file to the Office Support Staff for closure in the Claim Dispute Log and filing and tracking of certified mail receipts.

D. Reversal of Claim Decision: If PHS' decision regarding a claim dispute is reversed, in full or in part, the Appeals Specialist notifies the PHS Claims Supervisor to reprocess

<sup>7</sup> In the context of this standard and procedure, the word "Grievance" shall mean "Appeal".

<sup>8</sup> Adverse decisions are sent via certified mail

the claim(s), with sufficient information about the decision, so that the claim shall be paid in a manner consistent with the decision and in accordance with Standard F, within 10 business days of the date of the decision. Proof of effectuation is provided by the Claims Department to the Grievance & Appeals Department and placed in the claim dispute file. Claims paid outside of the 10 days of the date of service are paid with interest in accordance with AHCCCS contract requirements.

E. Provider Files a Request for State Fair Hearing following the PHS Final Decision of the Appeal:

1. Upon receipt of the written request for hearing, the Office Support Staff:
  - a. Date stamps the provider's written request letter or form and all accompanying documents to verify receipt of the request for State Fair Hearing was submitted in within 30 days of receipt of the PHS decision;
    - 1.) Requests for State Fair Hearing submitted outside the statutory timeframe shall be processed providing only a right to a State Fair Hearing specific to the issue of the timely filing of the request for State Fair Hearing.
    - 2.) Timely request for State Fair Hearing shall be processed.
  - b. Numbers the entire file in sequence from first received to last;
  - c. Copies the entire file;
  - d. Writes the Request for Hearing to AHCCCS letter (EXHIBIT D) that includes:
    - 1.) Provider's name;
    - 2.) Provider's AHCCCS ID number;
    - 3.) Provider's address and phone number (if applicable);
    - 4.) The date of receipt of the request for hearing;
    - 5.) A summary of the PHS actions undertaken to resolve the claim dispute and the basis for the determination;
    - 6.) Forwards all pertinent documentation including the request for hearing letter, all investigative and/or medical records PHS used to make the decision; and other information pertinent to the resolution of the claim dispute to AHCCCS Office of Legal Assistance (OLA) within five working days from the date the request was received by PHS from the provider or to be received by OLA no later than five working days from the date a verbal or written request to PHS from AHCCCS was made;
  - f. Requests a telephonic hearing, if appropriate; and
  - g. Updates the Provider Log to include the information regarding the request for hearing, date received, date forwarded to AHCCCS, dates of scheduled hearing, and outcome.
2. Upon notice of date and time of the State Fair Hearing scheduled by OLA with the Office of Administrative Hearing (OAH), the Office Support Staff:
  - a. Reserves and prepares the room for a telephonic hearing as needed;
  - b. Prepares and provides all documents to the PHS medical directors and staff who will attend the hearing;
  - c. Notifies the Pima County Deputy Attorney assigned to PHS if legal assistance is required;
  - d. Notifies all parties involved if the hearing is withdrawn, postponed or delayed;

- e. Records the outcome of the request for hearing and/or judicial decision in the provider claim dispute file;
- f. Closes the file upon the Director's Decision (within 30 days of the OAH decision). If the Director does not act within 30 days, the file is closed based on the decision of the OAH;
- g. Follows through on any directive in the Director' Decision letter by notifying the parties involved of action, if any, that needs to be taken; and
- h. Updates the provider's file and Provider Log accordingly.

3. PHS Representation at Administrative Hearing:

- a. The Grievance & Appeals Manager or Appeal Specialist, under the direction of the Manager, shall be present at all hearings, and in most cases, will represent PHS at all hearings.
- b. The Pima County Deputy County Attorney shall represent PHS in all cases where the Provider is represented by legal counsel.
- c. In cases involving Medical Necessity, PHS' Medical Director or Utilization Medical Management Manager may represent PHS.
- d. The Grievance & Appeals Manager or Appeal Specialist, under the direction of the Grievance Manager or Deputy County Attorney or PHS Administrator, shall call witnesses, including, but not limited to PHS employees, as appropriate, to testify on behalf of PHS.

F. Withdrawal of a request of a claim dispute or State Fair Hearing by provider:

- 1. If the provider withdraws the request to claim dispute, the Office Support Staff;
  - a. Requests the provider to submit the withdrawal in writing;
  - b. Acknowledges receipt of the withdrawal by written notice to the provider;
  - c. Notifies all parties involved;
  - d. Updates the provider's file and the Provider Log accordingly; and
  - e. Closes the file.
- 2. If the provider withdraws the request for a State Fair Hearing prior to the issuance of the notice of hearing by AHCCCS Office Administrative Hearing, the Office Support Staff:
  - a. Forwards the written request to AHCCCS Office of Legal Assistance;
  - b. Acknowledges receipt of the withdrawal by written notice to the provider;
  - c. Notifies all parties involved;
  - d. Places the provider's file in pending status until a notice is received from AHCCCSA to confirm their acceptance to withdraw the request for State Fair Hearing;
  - e. Updates the provider's file and the Provider Log accordingly; and
  - f. Closes the file upon receipt of the Director's decision to accept the withdrawal.
- 3. If the provider withdraws the request for a State Fair Hearing after the notice of hearing is issued by AHCCCS Office of Administrative Hearing, the Office Support Staff:
  - a. Notifies the provider to send the written request directly to AHCCCS Office of Administrative Hearing;

- b. Notifies all parties involved;
  - c. Places the provider's file in pending status until a notice is received from AHCCCS to confirm their acceptance to withdraw the request for State Fair Hearing;
  - d. Updates the provider's file and the Provider Log accordingly; and
  - e. Closes the file upon receipt of the Director's decision.
4. If AHCCCS denies a request for hearing under A.R.S. § 41-1092, et seq.,<sup>9</sup> the Office Support Staff, upon written receipt of the documentation:
    - a. Notifies all parties involved;
    - b. Updates the provider's file and the Provider Log accordingly; and
    - c. Closes the file.
- G. Closure of a claim dispute: A file is considered finalized and filed when:
1. The provider voluntarily withdraws the claim dispute or the request for a State Fair Hearing;
  2. The provider does not file a request for a State Fair Hearing within 30 days from the date the provider receives the Notice of Our Decision;
  3. The Director's decision has been rendered (within 30 days of the Administrative Law Judge's recommendations).
  4. The claim has been adjudicated on a reversal.

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<sup>9</sup> AHCCCSA may deny a request for State Fair Hearing if it is determined that: the request for hearing is untimely; the request for hearing is not for an action permitted under Article R9-Chapter 34; the request for hearing is moot, as determined by AHCCCS based on the factual circumstances of each case; or the sole issue presented is a federal or state law requiring an automatic change adversely affecting a provider. (R9-34-408). R9-34-409 includes provisions for a motion for rehearing or review.

H. Monthly Report:

1. The Grievance & Appeals Manager submits a monthly Claim Dispute Report to AHCCCS using the mandated Claim Dispute Report format. (ATTACHMENT A).
2. The Monthly Report is sent to AHCCCS by the first business day of the second month following the month being reported. The report is submitted to the following address:

Compliance Officer  
AHCCCS Division of Health Care Management  
701 East Jefferson St.  
(MD #6500 for Acute, MD #6100 for ALTCS)  
Phoenix, AZ 85034

3. The report includes a summary of findings, including trending information and any corrective or process improvement actions taken.
4. A copy of the report is maintained by the Grievance and Appeals Manager and is reviewed at the Quality Management/Process Improvement Quarterly Committee Meeting and by the Compliance Officer. Provider disputes are reviewed to identify trends and conditions that could determine changes in standards and procedures. Any changes implemented as a result of trending information are evaluated for effectiveness and a Process Improvement Project (PIP) report is completed and submitted to the Quality Management Manager.

I. Provider Grievances:

1. Provider grievances regarding issues other than a claim dispute are referred to and maintained by the Provider and Contract Services Division.

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PHS  
Pima Health System

Always Here For You

3950 S. Country Club Road, Suite 400 - Tucson, Arizona 85714 - (520) 243-8000

**Claim Dispute Acknowledgement**

(Date)

(Provider Contact Name)  
(Provider Name)  
(Address)  
(City, State, Zip)

**RE: CLAIM DISPUTE**  
**MEMBER NAME: (Member Name)**  
**AHCCCS ID #: (AHCCCS ID)**  
**DATES OF SERVICE: (Dates of Service)**  
**CLAIM DISPUTE FILE #: (PHS File Number)**

Pima Health System has received your request for a claim dispute(s) on (date) for the above-named member. At issue is the above-mentioned claim for the following reason: (summarize the issue). Pima Health System is looking into your appeal and will let you know of our decision as soon as possible, but no later than thirty (30) days.

Your claim dispute has been assigned to (Appeals Specialist name) for processing. Should you have any questions regarding the matter, or the claim dispute process, you may reach (Appeals Specialist name) at (phone number). If you have additional questions, I may be reached at (520) 243-8006.

Sincerely,

Grievance and Appeals Manager

PHS  
Pima Health System

Always Here For You

3950 S. Country Club Road, Suite 400 - Tucson, Arizona 85714 - (520) 243-8000

**NOTICE OF OUR DECISION**

(Date)

(Provider Contact Name)

(Provider Name)

(Address)

(City, State, Zip)

**Re: PROVIDER DISPUTE FILED**

Member Name: (Member Name)

AHCCCS ID#: (AHCCCS ID)

Dates of Service: (Dates of Service)

Date Received: \_\_\_\_\_

PHS File Number: (PHS File Number)

Pima Health System received your claim dispute on (Date). At issue was (summarize the issues involved and the resolution offered including references to the applicable statute, rule and procedure).

If you disagree with the resolution offered, you have the right to request a State Fair Hearing regarding Pima Health System’s decision. A request for a State Fair Hearing must be submitted in writing within thirty (30) days from receipt of this letter. The request must be sent to:

Pima Health System  
Attention: Appeals/Hearing Request  
3950 S. Country Club Rd. #400  
Tucson, AZ 85714

Your request will be forwarded to the AHCCCSA Office of Administrative Legal Services. Please note that if your request for hearing is not received within thirty (30) days, the issue to be heard will be the timeliness of the request for hearing. If you have any questions regarding the State Fair Hearing process, please call (520) 243-8006.

Sincerely,

Grievance and Appeals Manager

Pima Health System  
3950 S. Country Club Road, Suite 400 - Tucson, Arizona 85714 - (520) 243-8000

**Claim Dispute Extension**

(Date)

(Provider Contact Name)

(Provider Name)

(Address)

(City, State, Zip)

**RE: CLAIM DISPUTE**

**MEMBER NAME: (Member Name)**

**AHCCCS ID #: (AHCCCS ID)**

**DATES OF SERVICE: (Dates of Service)**

**CLAIM DISPUTE FILE #: (PHS File Number)**

Pima Health System is requesting an extension of (# of days) days on the above claim dispute. Because of the nature of this case, the decision is taking additional time beyond our thirty (30) day time limit to reach a resolution.

Your patience in this matter is deeply appreciated.

If you have any questions regarding this matter or the claim dispute process, please call 520-243-8006

Sincerely,

Grievance and Appeals Manager

**RE: CLAIM DISPUTE**

**MEMBER NAME: (Member Name)**

**AHCCCS ID #: (AHCCCS ID)**

**DATES OF SERVICE: (Dates of Service)**

**CLAIM DISPUTE FILE #: (PHS File Number)**

I, \_\_\_\_\_ representing \_\_\_\_\_ in signing below agree to an additional (Number of days) days for the above named claim dispute to be resolved. I understand that Pima Health System will offer a resolution to this grievance no later than (Date).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PHS  
Pima Health System

Always Here For You

**3950 S. Country Club Road, Suite 400 - Tucson, Arizona 85714 - (520) 243-8000**

**REQUEST FOR HEARING TO AHCCCSA**

(Date)

AHCCCS Office of Legal Assistance  
PO Box 25520, Mail Drop #6200  
Phoenix, AZ 85002-5520

**Re: PROVIDER REQUEST FOR HEARING**

**Name of Provider:** (Provider Name)  
**Provider ID #** (AHCCCS Provider Number)  
**Provider Address:** (Provider Address)  
**Provider Phone Number:** (Provider Phone)  
**Date of Receipt of Claim Dispute:** (Date)  
**Date of Receipt of Request for Hearing:** (Date)  
**Grievance File #** (PHS File Number)

Pima Health System is forwarding this file to the Office of Legal Assistance at the request of (Provider Name). At issue is (Summarize the issues involved and the actions undertaken to resolve the claim dispute and basis thereof).

Included with this request for hearing is the written request from the provider requesting the hearing, a copy of the entire Grievance/Appeals file with documentation regarding the investigations and/or medical records, Pima Health System's grievance decision, and any other information used to resolve the grievance necessary for AHCCCS to review.

If you have any questions regarding this request for hearing, I may be reached at (520) 243-8006.

Sincerely,

Grievance & Appeals Manager

AHCCCS CLAIM DISPUTE REPORT

		≤ 30 Days	≤ 45 days	>45 days	Total Number
A1	Ending Inventory from Previous Month	0	0	0	0
A2	Number of Claim Disputes Received This Month				0
A3	Number of Decisions Issued this Month				0
A4	Total Current Inventory as of End of Month	0	0	0	0
		<b>Total Number</b>			
B1	Upheld Disputes	0			
B2	Untimely Disputes	0			
B3	Overtured Disputes	0			
	I. Overtured due to incorrect handling	0			
	II. Overtured due to additional information submitted	0			
B4	Partially Overtured Disputes	0			
	I. Partially Overtured due to incorrect handling	0			
	II. Partially Overtured due to additional information submitted	0			
B5	Extensions Requested	0			
B6	Claims Forwarded for Reprocessing	0			
		<b>Total Number</b>			
C1	Hearing Requests Received During Reporting Period	0			
C2	Forwarded to AHCCCS within 5 days	0			

C3	Missed Forwarding Deadline	0			
C4	Total Number of Cancelled RFH	0			
	I. Those cancelled RFH due to Contractor Initiated Settlement Agreement	0			
C5	Director's Decisions Received in favor of the Provider	0			
C6	Director's Decisions Received in favor of the Contractor	0			
	<b>Top 5 Dispute Categories</b>	<b>Total Number</b>	<b>Percentage of Total Volume</b>		
D1	XXX (Category Code)		#DIV/0!		
D2	XXX (Category Code)		#DIV/0!		
D3	XXX (Category Code)		#DIV/0!		
D4	XXX (Category Code)		#DIV/0!		
D5	XXX (Category Code)		#DIV/0!		
D6					
	<b>Top 5 Disputing Providers</b>	<b>Total Number</b>	<b>Most Common Dispute Category</b>		
E6	Provider 1				
E7	Provider 2				
E8	Provider 3				
E9	Provider 4				
E10	Provider 5				