

Article 24. Out-of-Network Claim Dispute Resolution

R20-6-2401. Definitions.

The definitions in A.R.S. § 20-3111 and this Section apply to this Article.

1. "Allowed Amount" is the amount reimbursable for a covered service under the terms of the enrollee's benefit plan. The allowed amount includes both the amount payable by the insurer and the amount of the enrollee's cost sharing requirements.
2. "Alternative Arbitrator" is an individual who is mutually agreeable to the health insurer and health care provider to act as the arbitrator of a surprise out-of-network billing dispute. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator.
3. "Amount of the enrollee's cost sharing requirements" means the amount determined by the insurer prior to the dispute resolution process to be owed by the enrollee for out-of-network copayment, coinsurance and deductible pursuant to the enrollee's health care policy.
4. "Arbitrator" has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, arbitrator or other alternative dispute resolution professional who is contracted with the Department to arbitrate a surprise out-of-network billing dispute. Department staff may not serve as an Arbitrator.
5. "ARS 20-3113 Disclosure" means a written, dated document that contains the following information:
 - a. The name of the billing health care provider;
 - b. A statement that the health care provider is not a contracted provider;
 - c. The estimated total cost to be billed by the health care provider or the provider's representative for the health care services being provided;
 - d. A notice that the enrollee or the enrollee's authorized representative is not required to sign the ARS 20-3113 Disclosure to obtain health care services;
 - e. A notice that if the enrollee or the enrollee's authorized representative signs the ARS 20-3113 Disclosure, they may have waived any rights to request arbitration of a qualifying surprise out-of-network bill.
6. "Balance bill" means all charges that exceed the enrollee's cost sharing requirements and the amount paid by the insurer.
7. "Date of service" means the latest date on which the health care provider rendered a related health care service that is the subject of a qualifying surprise out-of-network bill.
8. "Days" as used in this Article means calendar days unless specified as business days and does not include the day of the filing of a document.
9. "Department" means the Arizona Department of Insurance or an entity with which it contracts to administer the out-of-network claim dispute resolution process.

10. "Enrollee's authorized representative" means a person to whom an enrollee has given express written consent to represent the enrollee, the enrollee's parent or legal guardian, a person appointed by the court to act on behalf of the enrollee or the enrollee's legal representative. An enrollee's authorized representative shall not be someone who represents the provider's interests.

11. "Final resolution of a health care appeal" means that a member has a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.

12. "Informal Settlement Teleconference" means a teleconference arranged by the Department that is held to settle the enrollee's qualifying surprise out-of-network bill prior to an Arbitration being scheduled. The parties to the Informal Settlement Teleconference are: (a) the enrollee or the enrollee's authorized representative; (b) the health insurer; and (c) the provider or the provider's representative.

13. "Qualifying surprise out-of-network bill" is a surprise out-of-network bill for health care services provided on or after January 1, 2019, that is disputed by the enrollee and:

- a. Is for health care services covered by the enrollee's health plan;
- b. Is for health care services provided in a network health care facility;
- c. Is for health care services performed by a provider who is not contracted to participate in the network that serves the enrollee's health plan;
- d. The enrollee has resolved any health care appeal pursuant to Chapter 15, Article 2, ARS that the enrollee may have had against the insurer following the health insurer's initial adjudication of the claim;
- e. The enrollee has not instituted a civil lawsuit or other legal action against the insurer or health care provider related to the surprise out-of-network bill or the health care services provided;
- f. The amount of the surprise out-of-network bill for which the enrollee is responsible for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least \$1,000.00; and
- g. One of the following applies:
 - i. The bill is for emergency services, including under circumstances described by A.R.S. § 20-2803(A);
 - ii. The bill is for health care services directly related to the emergency services that are provided during an inpatient admission to any network facility;
 - iii. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated ARS 20-3113 Disclosure;
 - iv. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated ARS 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;

v. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated ARS 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative chose not to sign the Disclosure;

vi. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated ARS 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative signed the Disclosure but the amount actually billed to the enrollee is greater than the estimated cost provided in the signed Disclosure.

R20-6-2402. Request for Arbitration.

A. Request for Arbitration. An enrollee may request dispute resolution of a surprise out-of-network bill by filing a timely Request for Arbitration with the Department on a Request for Arbitration form available on the Department's website.

B. Deadline for filing a Request for Arbitration with the Department. A Request for Arbitration must be received by the Department within one year after the date of service listed on the surprise out-of-network bill. If the enrollee filed a health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, the one year deadline is tolled from the date the enrollee filed the health care appeal to the date of the final resolution of the appeal.

C. Evaluation of the Request for Arbitration by the Department. Within 15 days after receipt of a Request for Arbitration, the Department shall do one of the following:

1. Determine that the surprise out-of-network bill is a qualifying surprise out-of-network bill and notify the enrollee, health insurer and health care provider that the Request for Arbitration qualifies for Arbitration;
2. Determine that the surprise out-of-network bill is not a qualifying surprise out-of-network bill and notify the enrollee of the reason for the Department's determination;
3. Determine that the Request for Arbitration is incomplete, or
4. Return the Request for Arbitration to the enrollee without making a determination if the enrollee's request should instead be filed as a health care appeal within the meaning of A.R.S. Title 20, Chapter 15, Article 2.

D. Request for additional information for an incomplete Request for Arbitration. If the Department determines that the Request for Arbitration is incomplete, the Department may send a written request for additional information to the enrollee, health insurer, health care provider or health care provider's billing company.

E. Time to respond to the Department's Request for Additional Information. The enrollee, health insurer, health care provider or the health care provider's billing company shall have 15 days from the date of the request to respond to the Department's Request for Additional Information.

F. Failure to respond to the Department's Request for Additional Information.

1. If the enrollee fails to respond to the Department's Request for Additional Information, the Department shall deny the enrollee's Request for Arbitration.
2. If either the health insurer or the health care provider or health care provider's billing company fail to respond to the Department's Request for Additional Information, the Department shall deem that the enrollee's Request for Arbitration qualifies for arbitration.

G. Receipt of Additional Information. Upon receipt of the additional information requested by the Department under subsection (D) of this Section, the Department shall determine, within seven days, whether the enrollee's Request for Arbitration qualifies for Arbitration and send the notice required under subsection (C)(1) or subsection (C)(2) of this Section, whichever applies.

H. Final Determination. The Department's determination whether an enrollee's Request for Arbitration qualifies for Arbitration is a final decision and not an appealable agency action within the meaning of A.R.S. § 41-1092(3). A claim that is the subject of a qualifying surprise out-of-network bill is not subject to the timely payment of claims law during the pendency of the Arbitration.

I. Enrollee's payment responsibility.

1. Notwithstanding any informal settlement or Arbitrator's Final Written Decision, the enrollee is responsible for only the following:

a. The amount of the enrollee's cost sharing requirements; and

b. Any amount received by the enrollee from the enrollee's health insurer as payment for the health care services at issue in a qualifying surprise out-of-network bill.

2. A health care provider may not issue, either directly or indirectly through its billing company, any additional balance bill to the enrollee for the same health care services.

R20-6-2403. Informal Settlement Teleconference.

A. Deadline to arrange the Informal Settlement Teleconference. Upon a determination that an enrollee has made a Request for Arbitration that qualifies for Arbitration, the Department shall arrange an Informal Settlement Teleconference between the parties within 30 days of notifying the enrollee that the enrollee's Request for Arbitration qualifies for Arbitration required by Section R20-6-2402(C)(1).

B. Notice of Informal Settlement Teleconference. At least 14 days prior to the scheduled date, the Department shall send a Notice of Informal Settlement Teleconference to the enrollee, the enrollee's authorized representative, the health insurer, the health care provider and the health care provider's representative informing them of the date, time and instructions on how to participate in the Informal Settlement Teleconference.

C. Health Insurer documentation. On or before the Informal Settlement Teleconference, the health insurer shall provide to the parties the enrollee's cost sharing requirements under the enrollee's health plan based on the qualifying surprise out-of-network bill.

D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the Informal Settlement Teleconference, it shall be subject to the following consequences:

1. If the health insurer, provider or provider's representative fails to participate in an Informal Settlement Teleconference scheduled by the Department, the participating party may notify the Department which shall promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.
2. If the enrollee or the enrollee's authorized representative fails to participate in the original Informal Settlement Teleconference, the original Informal Settlement Teleconference is terminated.
3. If the enrollee or the enrollee's authorized representative fails to participate in a rescheduled Informal Settlement Teleconference, the enrollee's Request for Arbitration is terminated.

E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. If the enrollee or the enrollee's representative fails to participate in the Informal Settlement Teleconference originally scheduled by the Department, the enrollee may request that the Department reschedule the Informal Settlement Conference. The enrollee's request to reschedule must be received by the Department within 14 days after the originally scheduled Informal Settlement Teleconference. Failure to submit a request to the Department to reschedule the Informal Settlement Teleconference within the 14 day period terminates the enrollee's Request for Arbitration.

F. Notification to the Department after the Informal Settlement Teleconference: Within seven days after the date of the Informal Settlement Teleconference, the health insurer shall:

1. Notify the Department whether a settlement was reached between the parties; and
2. If a settlement was reached, notify the Department of the terms of the settlement on a form prescribed by the Department.

G. Failure to settle. If the parties fail to settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the Department shall arrange for the Arbitration.

H. Settlement. If the parties settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the health insurer shall remit its portion of the payment to the health care provider within 30 days after the Informal Settlement Teleconference. A claim that is reprocessed by a health insurer as a result of informal settlement is not in violation of A.R.S. § 20-3102(L).

R20-6-2404. Arbitrators.

A. Contracted entities. The Department shall contract with one or more persons to provide Arbitrators. The Department must have a list of at least four Arbitrators to assign to Arbitrations. The Department shall publish the list of contracted entities and a list of each entity's qualified Arbitrators on its website.

B. Arbitrator Qualifications. Any person contracting with the Department must be able to provide Arbitrators who possess at least three years of experience in health care services claims.

C. Alternative Arbitrators. A health insurer and provider may mutually agree to use an Alternative Arbitrator if either the health insurer or the health care provider objects to an Arbitrator appointed by the Department.

D. Appointment of an Arbitrator.

1. The Department shall appoint an Arbitrator for each Arbitration.

2. If the health insurer and health care provider do not agree to the Arbitrator appointed by the Department, they shall either:

a. Mutually agree to use an Alternative Arbitrator; or

b. Participate in the following procedure:

i. The Department shall assign three Arbitrators.

ii. The health insurer shall strike one Arbitrator.

iii. The health care provider shall strike one Arbitrator.

iv. If one Arbitrator remains, the Department shall appoint the remaining Arbitrator to the Arbitration.

v. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators.

R20-6-2405. Before the Arbitration.

A. Enrollee's duties. Before the Arbitration, the enrollee shall:

1. Pay or make arrangements in writing to pay to the health care provider the amount stated by the health insurer in the Informal Settlement Teleconference which shall be the total amount of the enrollee's cost sharing requirements due for the health care services that are the subject of the qualifying surprise out-of-network bill.
2. Pay to the health care provider any amount that the enrollee has received from the health insurer as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.

B. Health insurer's duties. Before the Arbitration, the health insurer shall:

1. Remit any amount due to the health care provider if the health care insurer pays for out-of-network services directly to health care providers and the health insurer has not remitted any amounts due.

R20-6-2406. The Arbitration.

A. Conduct of Arbitration. An Arbitration of a qualifying out-of-network surprise bill shall be conducted:

1. Telephonically unless the parties agree otherwise;
2. With or without the enrollee's participation;
3. Within 120 days after the Department's Notice of Arbitration unless agreed otherwise by the parties; and
4. For a maximum duration of four hours unless agreed otherwise by the parties.

B. Arbitrator's Determination. The Arbitrator or Alternative Arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.

C. Allowable Evidence. The Arbitrator or Alternative Arbitrator shall allow each party to provide relevant information for evaluating the qualifying surprise out-of-network bill including:

1. The average contracted amount that the health insurer pays for the health care services at issue in the county where the health care provider performed the health care services;
2. The average amount that the health care provider has contracted to accept for the health care services at issue in the county where the health care provider performed the services;
3. The amount Medicare and Medicaid pay for the health care services at issue;
4. The health care provider's direct pay rate for the health care services at issue, if any, under A.R.S. § 32-3216;
5. Any information that would be evaluated in determining whether a fee is reasonable under title 32 and not excessive for the health care services at issue, including the usual and customary charges for the health care services at issue performed by a health care provider in the same or similar specialty and provided in the same geographic area; and
6. Any other reliable sources of information, including databases, that provide the amount paid for the health care services at issue in the county where the health care provider performed the services.

D. Final Written Decision. Within 10 business days following the Arbitration, the Arbitrator or Alternative Arbitrator shall issue a Final Written Decision and provide a copy to the enrollee, the health insurer, the health care provider, the health care provider's billing company (if applicable) and the health care provider's authorized representative (if applicable).

E. Payment of the claim. The health insurer shall remit its portion of the payment awarded by the Arbitrator or Alternative Arbitrator to the health care provider within 30 days of the date of the Final Written Decision. A claim that is reprocessed by a health insurer as a result of the Arbitration is not in violation of A.R.S. § 20-3102(L).

F. Payment of the Costs of Arbitration. The health insurer and health care provider shall make payment arrangements with the Arbitrator or Alternative Arbitrator to pay their respective shares of the costs of

the Arbitration within 30 days after the date of the Final Written Decision. The respective shares of the costs of Arbitration are determined as follows:

1. The enrollee is not responsible for any portion of the cost of the Arbitration.
2. The health insurer and the health care provider shall share the costs of the Arbitration equally unless one of the following exceptions applies:
 - a. The health insurer and health care provider agree to share the costs of the Arbitration in non-equal portions.
 - b. The health insurer pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.
 - c. The health care provider or the health care provider's representative pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.

G. Confidentiality. In connection with the Arbitration of a qualifying surprise out-of-network bill, all of the following apply:

1. All pricing information provided by a health insurer or health care provider is confidential.
2. Pricing information provided by a health insurer or health care provider may not be disclosed by the Arbitrator, Alternative Arbitrator or any other party participating in the Arbitration.
3. Pricing information provided by a health insurer or health care provider may not be used by anyone, except the party providing the information, for any purpose other than to resolve the qualifying surprise out-of-network bill.
4. All information received by the Department in connection with the Arbitration is confidential and may not be disclosed to any person except the Arbitrator or Alternative Arbitrator.

H. Arbitrator's Report. At the conclusion of each Arbitration, the Arbitrator shall produce a report to the Department that contains the following information:

1. Date of Arbitration;
2. Date the Arbitrator issued the Final Written Decision;
3. Whether the parties settled the qualifying surprise out-of-network bill during the Arbitration;
4. The initial amount billed by the health care provider;
5. The payment amount awarded to the health care provider; and
6. Any other information the Department may request an Arbitrator to report prior to an Arbitration.