February 27, 2025

Industrial Commission of Arizona

800 W Washington St

Phoenix, AZ 85007

Attn: MRO Office

Dear ICA Commission:

I would like to respectfully make comment and recommendations regarding the below proposal by the ICA on page 17.

5. Healthcare care providers shall bill the code that most accurately describes the service performed. If an insurance carrier, self-insured employer, or claims processing representative determines that the documentation submitted does not support the procedure code billed, the payment to the healthcare care provider may be appropriately adjusted based on Fee Schedule reimbursement values. See A.R.S. § 23-1062.01. The payer shall provide documentation justifying the adjustment and clearly outline the process a healthcare care provider may follow to appeal the determination. Payers shall not downcode medical billings under the Arizona Physicians' & Pharmaceutical Fee Schedule. Downcoding is dened as a payer changing a code in a payment remittance to a code at a lower service level than was billed by the healthcare provider. As applicable, the health care provider may resubmit the bill with documentation that addresses the reason for the adjustment.

We are so very grateful to the commission to recognize the challenges that providers face to be reimbursed for services rendered. However, I do foresee potential challenges arising from the statement noted above that may need to be addressed.

1. The whole claim being denied because the carrier does not want to pay or disagrees of the level of service performed. This would create an abundance of denials in addition to a negative cash flow for providers. We would ask the commission to add verbiage stating carrier cannot and should not deny the "whole claim" due to differences in opinion of level of service.

2. It would be our recommendation that the Commission add to the above ruling that if the carrier cannot provide the proper documentation with the coding change within 30 days, the claim must be paid as submitted. Suggesting the burden of proof lies with the carrier and not the provider of service. This is in response to the abundant games the review companies (on behalf of the carriers) play to deny or delay payments.

3. Can the Commission please bold the following statement "The payer shall provide documentation justifying the adjustment and clearly outline the process a healthcare care provider may follow to appeal the determination".

4. We would also like to recommend a process for disputes beyond the "appeal". Such as, a moderator or peer review for claims that cannot be resolved between the provider and carrier.

Again, we appreciate the hard work of the MRO office to help providers in claim payments.

Respectfully submitted,

Cynthia Everlith

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On behalf of Mark A Greenfield, DO PC