information related to changes in commercial insurance carriers for new and existing members. The monitoring of encounter denials identifies variances between AHCCCS and P/GLTC TPL data. Any discrepancies are forwarded to the TPL Specialist for verification and system updates as needed. Overpayments are recouped from the provider, as per AHCCCS guidelines, through the claims system and adjusted encounters are submitted to AHCCCS.

Pertinent information is verified telephonically by the TPL Specialist and entered into both systems. As ALTCS members approach the Case Management review date, the TPL specialist re-verifies information in the system. Data are provided to case management for comparison to information received from the member during their review. The AHCCCS Client Assessment and Tracking System (CATS) is monitored to ensure data is consistent. Variances are reported to AHCCCS via the online notification process.

Insurance information also flows from the claims process. If a member's record reflects other coverage, and the bill is submitted without an EOB from the other carrier, the claim denies pending other coverage information/EOB. If the system reflects no other coverage and there is an EOB attached, the information is routed to the TPL Specialist for coverage verification. The verification date is noted in the member record, the claim is paid, and AHCCCS is notified. The TPL Specialist also forwards new COB information to the Lead Claims Specialist for a claims payment retrospective review to identify any payments made with P/GLTC as primary payor. Whatever the source, P/GLTC pursues post payment recoveries. The claim is adjusted and overpayments are recouped from the provider from future claims submissions. Per the AHCCCS Recoupment policy, recoupments over $50,000 must be pre-approved by AHCCCS; no recoupments are made beyond 12 months after the date of service. Any related encounters are replaced in order to reflect the accurate/adjusted payment or recoupment. If potential third party payors are discovered, i.e. for motor vehicle accidents, P/GLTC notifies AHCCCS and provides the pertinent information. Claims that contain diagnosis codes 800–999 (trauma codes) are reviewed, investigated, and reported monthly to AHCCCS for subrogation. Other reports reviewed are TPL audits, AHCCCS required Verification of Services, and Cost Avoidance.

Claims Inquiries

There is a designated Provider Liaison whose responsibilities include response to provider calls regarding claims status, payment information, claims dispute procedures, and provider billing instruction. The Claim Assistance line connects to the direct line of the Provider Liaison, once the call is answered, without cycling through an automated menu. Established inquiry response standards are one to two business days. Current statistics reflect an average inquiry turnaround time of within 24 hours. The Provider Liaison logs all calls and resolutions. The Claims Manager analyzes this log monthly and identifies needs for provider training. This information is relayed to the appropriate Provider Relations Representative and corrective action is discussed. If a call goes to voice mail, the message provides information for accessing the website, faxing multiple claim inquiries and the availability of EFT process.

Providers have direct website access through P/GLTC or Pinal County. Information available includes:

- Claims status
- Member eligibility
- Rate codes
- Searchable provider directory

Online inquiry inquiries are directed to the claims unit via e-mail. The issue is researched and an e-mail response/resolution is sent to the provider. In the case of complex issues, a Claims Specialist calls the office directly for a one-to-one conversation with the provider office staff.

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Exhibit 7-1
Claims Adjudication Process

AHCCCS requirement to pay clean claims = 30 days,
P/GLTC Average time = 18 days

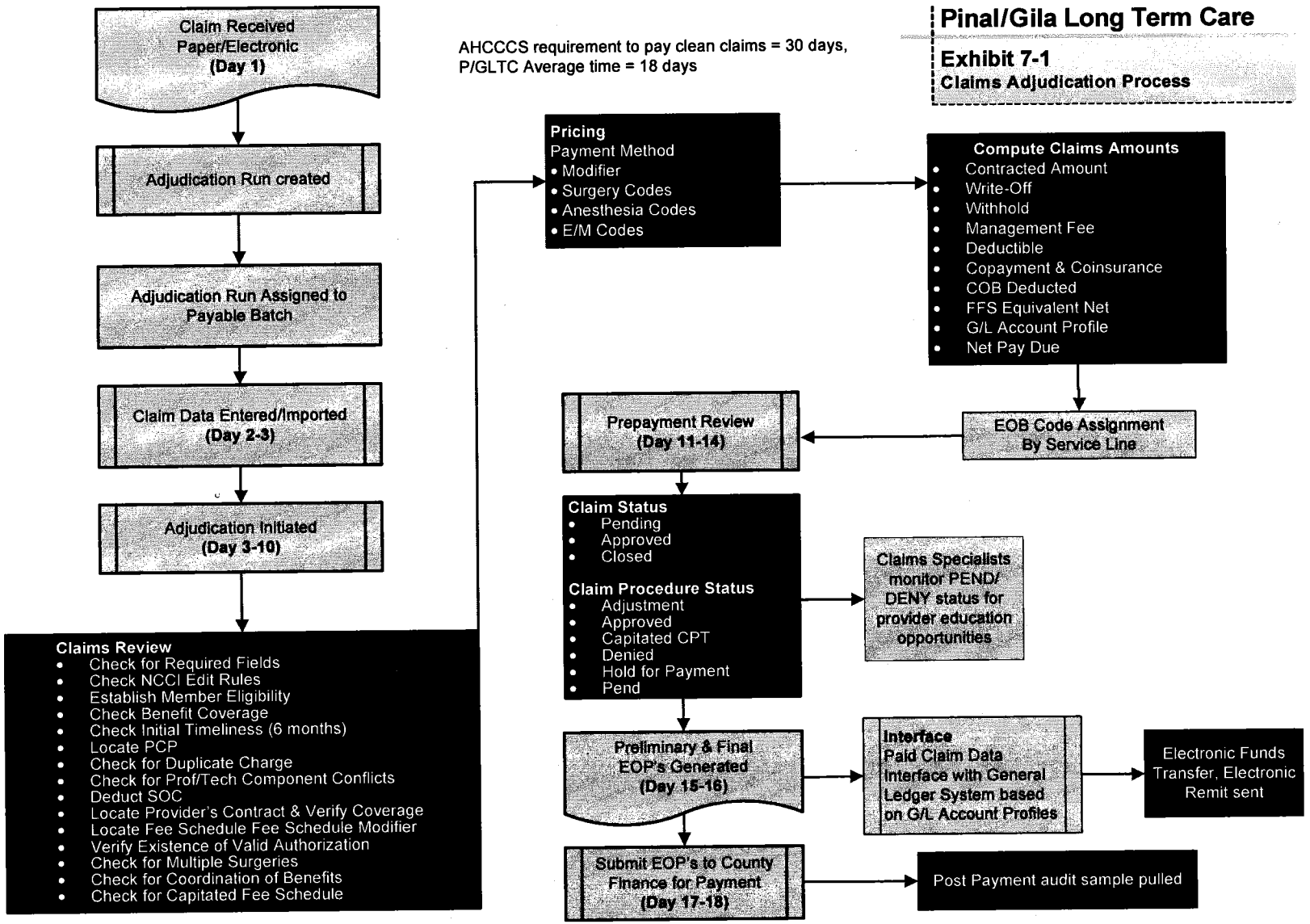

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Exhibit 7-2
Electronic Claims
Inbound 837