Louisiana Department of Health
Informational Bulletin 13-2
Revised September 1, 2017

Health Plan Provider Claims Disputes and Resolution

The Health Plan requirements for claims dispute management are located in Section 17.6.2 of the contract. Each Health Plan is required to develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. Providers should primarily refer to the Health Plan's provider website for details on this process at the following web addresses:

Aetna: http://www.aetnabetterhealth.com/louisiana/providers/

Healthy Blue: https://providers.healthyblue.la.com

AmeriHealth Caritas Louisiana:
http://www.amerihealthcaritasla.com/provider/resources/grievances/index.aspx

Louisiana Healthcare Connections: https://www.louisianahealthconnect.com/content/dam/centene/louisiana-health-connect/pdfs/medicaid-provider/Claim-Dispute-Form.pdf

United Healthcare: http://www.uhccommunityplan.com/health-professionals/la.html

This bulletin provides a reference guide to the current processes for claims disputes for each of the Health Plans: Aetna, Healthy Blue, AmeriHealth Caritas Louisiana, Louisiana Healthcare Connections and United Healthcare Community Plan.

The Claims Dispute Process allows providers to request a review of claim(s) denied by the Health Plan. All Plans have a first and second level request for review. Providers do not have the right to a State Fair Hearing for claims issues. However, if the provider is not satisfied with the decision and/or resolution through the Health Plan's internal process, the provider may request arbitration through the Health Plan. The arbitration would be performed by a private, independent arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. Arbitration conducted pursuant to claims dispute is binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless the Health Plan and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

In addition, the Health Plan shall systematically capture the status and resolution of all claims disputes as well as all associated documentation. The Health Plans are required to submit a monthly report of all provider complaints, including claims disputes and appeals of medical necessity decisions to Healthy Louisiana including the issue and the resolution. These reports will be closely monitored by Healthy Louisiana for trends and matters that may require corrective action by the Health Plan.

Each Health Plan has provided a synopsis of their established processes for addressing and escalating provider claims disputes. Healthy Louisiana strongly recommends that providers document the name of the Plan representative(s) with whom they speak or communicate via email along with the time and date; and provide that information as issues are escalated.

When emailing personal health information (PHI) to the Health Plan or Healthy Louisiana, providers must use secure email as described in Section 16.7.4 of the managed care organization (MCO) contract.

Ctrl+Click logo to reach each Plans' provider website	aetna AETNA BETTER HEALTH® OF LOUISIANA	Healthy Blue	AmeriHealth Caritas Louisiana	louisiana healthcare connections	UnitedHealthcare Community Plan
Inquiries Regarding Denied Claims	**1-855-242-0802**	**1-844-521-6942**	**1-888-922-0007**	**1-866-595-8133**	**1-866-675-1607**
FIRST LEVEL REVIEW					
Time Requirements	Request for reconsideration review **must be received within 90 calendar days** of the Remittance Advice paid date or recoupment date **A determination will made within 30 days of receipt.**	Request for reconsideration review **must be received within 90 calendar days** of the Explanation of Payment (EOP) paid date or recoupment date **A determination will made within 30 days of receipt.**	Request for reconsideration review **must be received within 90 calendar days** of the original denial. **A determination will be made within 30 days of receipt.**	Request for reconsideration review **must be received within 90 calendar days** from the date of notification of payment or denial. **A determination will be made within 30 days of receipt.**	Request for reconsideration review **must be received within 90 calendar days** from the date of notification of payment or denial. **A determination will be made within 30 days of receipt.**
Format Required	Request may be submitted verbally and followed up in writing using the dispute form located on the Health Plan's website under Provider.	Request must be submitted in writing using the dispute form located on the Health Plan's provider portal.	Request must be submitted in writing. See Health Plan's website under "Claims Dispute Documentation" for instructions.	Request must be submitted in writing using the dispute form located on the Health Plan's provider website.	Reconsideration Form detailing the reason for reconsideration. A copy of this form can be obtained at: 1-866-675-1607 OR A provider always has the option to submit a claims reconsideration request through our BayouCloud.healthlink.com portal.
Address for Submission	Aetna Better Health of Louisiana, Provider Services Department **Attention: Provider Dispute** 2400 Veterans Memorial Blvd., Suite 200 Kenner, LA 70062	Healthy Blue Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599	Attn: 1st Level Provider Dispute AmeriHealth Caritas Louisiana P.O. Box 7323 London, KY 40742	Attn: Reconsideration Louisiana Healthcare Connections P.O. Box 4040 Farmington, MO 63640-3826	Attn: Reconsideration UnitedHealthcare Community Plan PO Box 31341 Salt Lake City, UT 84131-0341
SECOND LEVEL REVIEW	Always Include first level review documentation with request for second level review.				

Time Requirements	**Must be received within 90 calendar days** of the date on the determination letter from original request for reconsideration. **The resolution will be decided within 30 days of receipt.**	**Must be received within 30 calendar days** of the date on the determination letter from your original request for reconsideration. **The resolution will be decided within 30 days of receipt.**	**Must be received within 30 calendar days** of the date on the determination letter from original request for reconsideration. **The resolution will be decided within 30 days of receipt.**	**Must be received within 90 calendar days** of the date on the determination letter from original request for reconsideration. **The resolution will be decided within 30 days of receipt.**	**Must be received within 90 calendar days** of the date on the determination letter from original request for reconsideration. **The resolution will be decided within 30 days of receipt.**
Format Required	Dispute can be submitted verbally and followed up in writing using the claims dispute form located on Health Plan's website.	Dispute must be submitted in writing by using the claims dispute form located on the Health Plan's provider website.	Dispute must be submitted in writing.	Dispute must be submitted in writing using the claims dispute form located on the Health Plan's website.	Dispute must be submitted in writing using the claims dispute form located on the Health Plan's website.
Address for Submission	Aetna Better Health of Louisiana Appeal and Grievance Department 2400 Veterans Memorial Blvd., Suite 200 Kenner, LA 70062	Payment Dispute Unit Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599	Attention: 2nd Level Provider Dispute AmeriHealth Caritas Louisiana PO Box 7323 London, KY 40742	Louisiana Healthcare Connections Attn: Claim Dispute P.O. Box 3000 Farmington, MO 63640-3800	Attention: Second Level Appeal UnitedHealthcare Community Plan PO Box 31341 Salt Lake City, UT 84131-0341
ARBITRATION PROCESS					
Time Requirements	30 calendar days from the date of the second level dispute determination	30 calendar days from the date of the second level determination decision/resolution	30 calendar days from the date of the second level dispute determination.	Within 15 business days of date of disposition of the second level disputed claim response	30 calendar days from the date of the second level dispute determination
Format Required	Request must be submitted in writing. **Include decisions from first and second level review.**	Request must be submitted in writing. **Include decisions from first and second level review.**	Request must be submitted in writing. **Include decisions from first and second level review.**	Request must be submitted in writing using the claim dispute form located on the Health Plan's website. **Include decisions from first and second level review.**	Request must be submitted in writing. **Include decisions from first and second level review.**
Address for Submission	Aetna Better Health of Louisiana Appeal and Grievance Department 2400 Veterans Memorial Blvd., Suite 200 Kenner, LA 70062	Healthy Blue 3850 N. Causeway Blvd. Suite 600 New Orleans, LA 700002	Request for Arbitration c/o Legal Affairs Department 200 Stevens Drive Philadelphia, PA 19113	Attn: President Louisiana Healthcare Connections 7700 Forsyth Blvd. St. Louis, MO 63105	UnitedHealthcare Community and State Attention: Claims Administrative Appeals & Request for Arbitration P.O. Box 31364 Salt Lake City, UT 84131-0364