AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Provider Disputes	Page:	1 of 9
Department:	Appeal and Grievance	Policy Number:	6300.00
Subsection:		Effective Date:	02/01/2015
Applies to:	■ Medicaid Health Plans		

PURPOSE:

This policy describes Aetna Better Health's process related to receiving, managing and responding to Provider disputes including issues regarding contracts, coding edits and missing documentation.

STATEMENT OF OBJECTIVE:

Aetna Better Health and the contracted health care provider are responsible for resolving any contractual issues that may arise between the two (2) parties, and for ensuring that no issue will disrupt or interfere with the provisions of services to the member through a dispute process. Contractual issues will be settled according to the terms of their contractual agreement. Contracted providers may also file a complaint (*See policy 6300.35 and 6300.38*) or request a reconsideration of any administrative function or policy of the health plan as provided by State regulations. Both contracted and non-contracted health care providers may file disputes related to claim payments or claim denials in relation to clean claim requirements. Any change to the original claim including but not limited to: Missing information (consent form, medical records, primary carrier's EOB, etc) are considered claims correspondence. Claims correspondence may be resubmitted with the missing or corrected documentation through the claims department and are subject to claims processing procedures and timeframes.

DEFINITIONS:

AMA Claim Edit Team (also known as a Medical Claims Review Nurse [MCRN], or Quality Management Nurse Consultant [QMNC])	A Claims Review Nurse responsible for the review of disputes related to clinical coding of the following items: • Claim Check Edits • iHealth/Cotiviti Edits • Verisk Edits • ER Review Level of Care
CICR	Claims Inquiry Claims Research
Clean Claim	A clean claim is defined as a claim that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Non Participating Network Provider (also known as non par provider, non contracted provider)	A health care provider, either an individual or facility, who does not have a written provider agreement with Aetna Better Health and is not credentialed by Aetna Better Health.
Non Participating Provider Disputes (also known as non par provider, non contracted provider)	A dispute request between a non contracted provider and Aetna Better Health expressing dissatisfaction with claim payment amounts or claim denial decisions. **Providers shall have one hundred eighty (180) calendar days from the date of denial to dispute the denied claim.[1]** Non contracting provider disputes do not include pre-service disputes or disputes related to medical necessity and the decision of Aetna Better Health is final.
Participating Network Provider (also known as Provider, par provider, contracted provider)	A health care provider, either an individual or facility, who has a written provider agreement with and is credentialed by Aetna Better Health and who participates in Aetna Better Health's Provider Network or an individual or facility that is subcontracted by Aetna Better Health to serve Aetna Better Health members.
Participating Provider Disputes (also known as Provider, par provider, contracted provider)	A dispute request between a contracted provider and Aetna Better Health expressing dissatisfaction with any administrative function including policies and claim payment amounts or claim denial decisions based on contractual provisions. **Providers shall have one hundred eighty (180) calendar days from the date of denial to dispute the denied claim.[2]**

[1] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.18.12.5
[2] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.18.12.5

	Disputes related to missing information may be resubmitted as claims correspondence. Claim correspondence is different from a claim appeal. Correspondence includes any documentation submitted to that was needed to process a claim that represents a change to the original claim, including but not limited to: missing information (consent form, medical records, primary carrier's EOB) etc. Once the information is received through the dispute process the documentation will be used to reprocess the claim. Provider disputes do not include pre-service disputes that were denied due to not meeting medical necessity. Pre-service items related to medical necessity are processed as member appeals and subject to member appeal policies and timeframes. Provider disputes related to administrative functions, policies and procedures are processed as provider complaints.
Provider Appeal (Internal Level 2)	A request by provider to appeal actions of the health plan when the provider: • Has a claim for reimbursement, or request for authorization and Aetna Better Health did not render the decision timely. • Has a claim for reimbursement that has been denied or paid differently than expected when all necessary documentation was submitted prior to or with the claim submission that was not resolved to the provider's satisfaction. • Has a claim for reimbursement that has been denied or paid differently than expected after submission of the missing documentation with the reconsideration. • Has rendered services for a member but has not submitted the claim yet. An appeal is the formal process for resolving provider claim reconsiderations.

	Appeals must be requested within sixty (60) calendar days of the date on the determination letter from the original request for claim reconsideration. **Requests to appeal post-service items are always on behalf of the provider and considered a provider appeal subject to the timeframes and procedures in this policy. They are not eligible for expedited processing.** **Requests to appeal pre-service items on behalf of the member are considered member appeals and subject to the member appeal timeframes and policies.**
Provider Claim Reconsideration (Internal Level 1)	A request by a provider for reconsideration of a partially or totally denied claim
Provider External Appeal	The provider and/or the provider's representative, acting on behalf of the provider, may request an outside review of the final adverse determination made by the organization through its internal appeal process; also known as "IRO Review."
Provider Complaint	Any written or verbal expression of dissatisfaction by a provider, against Aetna Better Health policies, procedures or any aspect of Aetna Better Health's administrative functions including complaints, about any matter other than an appeal, which is covered under the Provider Appeals policy. Possible subjects of complaints include, but are not limited to,

	issues regarding: • Administrative issues • Payment and reimbursement issues • Dissatisfaction with the resolution of a dispute • Aetna Better Health staff service or behavior • Vendor staff service or behavior • Sanctions, suspensions or terminations imposed by Aetna Better Health against network providers or contractor(s) [3] A complaint is the formal process for resolving provider disputes not related to an appeal or claim reconsideration. All expressions of dissatisfaction resulting from receipt of a claim or authorization denial are automatically classified as an appeal.
Provider Dispute Form	Internal Aetna Better Health form to be submitted by the provider to document a dispute.
State Agency Name and Acronym	Louisiana Department of Health (LDH)

LEGAL/CONTRACT REFERENCE:

- 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 10.6
- **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.18.12**
- State and federal rules and regulations

FOCUS/DISPOSITION:

Scope

Aetna Better Health's Provider Dispute process makes available an issue resolution process when there is dissatisfaction between Aetna Better Health and the provider. Aetna Better Health

[3] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 7.14.13

will ensure that no punitive action is taken against a provider who files an issue. Issues between a provider and Aetna Better Health will not disrupt or interfere with the provisions of services to the member. Aetna Better Health will administer an equitable, timely, and balanced review of provider issues. The issue will be reviewed and processed according the definitions in this document, including by not limited to Disputes, Claim Reconsiderations, Appeals and Complaints. Provider Claim Disputes do not include pre-service items that were denied due to not meeting medical necessity. Pre-service denials are processed as member appeals and are subject to member policies and timeframes.

Responsibilities

It is Aetna Better Health's policy that the resolution of issues regarding the interpretation of the State agency approved Aetna Better Health contract(s) is a matter solely between Aetna Better Health and the provider. Aetna Better Health will inform providers about this policy through the Provider Handbook and other mediums, to include newsletters, training, provider orientation, the website Provider Dispute form and by the provider calling their Provider Relations representative.

Aetna Better Health's decision is final for non-contracted provider claim disputes unless State regulations provide additional recourse.

Claims Inquiry Claim Research (CICR) representatives and Aetna Better Health's Provider Relations representatives are available to discuss all provider issues. Upon receipt the facts of the issue are reviewed to determine classification of an inquiry, dispute, claim reconsideration, appeal or complaint. A provider's dissatisfaction with an issue covered by this policy and may be followed by the Provider Appeal or Complaint process as applicable.

Any complaints received about the health plan staff, contracted vendors or members of the plan are classified as Provider Complaint and will be automatically forwarded to the Appeal and Complaint department for processing as a provider complaint.

Disputes Process

To promote a quicker resolution process, the content of the request is reviewed, regardless of terminology used by the provider, and triage of the request is completed to determine the appropriate classification for processing.

The provider may be asked to complete and submit the Provider Dispute Form with any appropriate supporting documentation to the designated department listed on the form. The Provider Dispute Form is accessible on Aetna Better Health's website, via fax or by mail. Aetna Better Health will review and resolve the case according to classification and will notify the provider of its decision by phone, email or fax or by surface mail.

Requests for claim disputes that are received with a supporting claim at the health plan address, the claims correspondence is forwarded to the plan specific claims Post Office (P.O.) Box for claim reprocessing. When the claim includes additional clinical information in support of their request or any review for medical necessity, it may be pended to the AMA Claim Edit Team or the health plan Utilization Management (UM) department respectively, for review and decision making as follows:

AMA Claim Edit Team - Clinical coding review items:
- Claim Check Edits
- iHealth/Cotiviti Edits
- Verisk Edits

ER Review Level of Care

UM:
- All other claim reconsiderations that come in with a claim form and clinical information such as a retro authorization review

Disputes Resolution

Upon completion of the dispute the provider will receive a new remittance advice showing the determination. In the event that a provider remains dissatisfied with the dispute determination the provider may file a claim reconsideration, appeal or complaint as applicable in accordance with State specific regulations. **Aetna Better Health will adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the disputed claim.**[4]

If available the process to submit an appeal or complaint is included in the Aetna Better Health Provider Appeal and Claim Reconsideration policy, Aetna Better Health Provider Complaint

[4] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.18.12.4**

policy, on the Aetna Better Health website as well as the Aetna Better Health Provider Handbook.

Upon request any updates and/or changes to currently approved Provider Dispute processes will be submitted to the State agency for approval prior to the implementation of the changes, unless otherwise regulated by law.

OPERATING PROTOCOL:

Systems

- Business operating system
- Aetna Better Health website and phone system

Measurement

- The count of claims reprocessed due to the receipt of additional information received and resolved

Reporting

- The status and resolution of all claim reconsiderations will be documented including any correspondence or additional documentation provided.

INTER-/INTRADEPENDENCIES:

Internal

- Claims Inquiry Claims Research
- Provider Relations
- Utilization Management

External

- LDH
- Network providers

Aetna Better Health

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