AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Provider Complaints	Page:	1 of 11
Department:	Appeal and Grievance	Policy Number:	6300.35
Subsection:		Effective Date:	02/01/2015
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to describe Aetna Better Health's obligations in regard to a provider's right to file a formal complaint. Aetna Better Health has established a provider complaint process that expedites the timely and effective resolution of complaints between the health plan and providers. This system is specific to providers and does not replace the member grievance system which allows a provider to submit a grievance on behalf of a member. **If a provider submits a grievance on behalf of a member, the requirements of member grievance system will apply.**

STATEMENT OF OBJECTIVE:

Aetna Better Health and the participating health care provider are responsible for resolving any contractual disputes that may arise between the two (2) parties through the complaint process, and for confirming that no complaint will disrupt or interfere with the provisions of services to the member. Complaints will be settled according to the terms of the provider's contractual agreement. Participating providers may also complaint about any administrative functions or policies of the health plan following provider dispute resolution and in accordance with any regulations. Both participating and non participating health care providers may file complaints related to health plan staff, contracted vendors and members.[1]

As part of the provider complaint process Aetna Better Health will confirm that the provider complaint process is included in the Aetna Better Health Provider Handbook and on the website. Aetna Better Health will also verify that the provider complaint process includes instruction about contacting Aetna Better Health to file a complaint.

DEFINITIONS:

Adverse Action[2]	**For the purposes of this subsection, an adverse action is defined as:** • **The denial or limited authorization of a requested service, including the type or level of service;** • **The reduction, suspension, or termination of a previously authorized service;**

[1] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.2**
[2] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.3**

	• **The failure to provide services in a Timely manner, as defined in this section; or** • **The failure of the MCO to act within the timeframes provided in this Contract.**
Appeal and Grievance Application	A highly customizable complaint, grievance and appeal application to capture, process, store, and retrieve detailed information on each complaint, grievance or appeal received.
Member Grievance	Any written or verbal expression of dissatisfaction by a member, member representative including a provider authorized in writing to act on the member's behalf, including complaints, about any matter other than an adverse benefit determination.
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 Dispute	A dispute between a non contracted provider and Aetna Better Health expressing dissatisfaction with claim payment amounts or claim denial decisions. 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. Items related to medical necessity decisions are processed as member appeals and subject to member appeal policies and timeframes.
Participating Network Provider (also known as Provider par 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 Dispute	A dispute 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; including but not limited to resubmitted claims to meet clean claim requirements, reconsiderations, issues related to coding, fee schedules or contracting and may also include retro authorization reviews outside of the reconsideration timeframe. 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 Complaint	**Any verbal or written expression, originating from a provider and delivered to any employee of the Contractor, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Contractor, including, but not limited to, an adverse action, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies.**[3] ~~Any written or verbal expression of dissatisfaction by a provider, against Aetn 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

[3] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.1**

	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).4 A complaint is the formal process for resolving provider disputes not related to an appeal. All expressions of dissatisfaction resulting from receipt of a claim or authorization denial are automatically classified as an appeal.
Provider Complaint System	The process in which the provider is able to file a complaint and the system for documenting and tracking complaints and their resolutions.**5**
State Agency Name and Acronym	Louisiana Department of Health (LDH)
Timelines	The organization makes decisions within thirty (30) calendar days of receipt of the provider complaint.

LEGAL/CONTRACT REFERENCE:

- 2020 Louisiana Medicaid Managed Care Organization Statement of Work Sections 7.9 and 10.6
- **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9 Provider Complaint System**
- State and federal rules and regulations
- 42 C.F.R. § 438.400 – 438.424

[4] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 7.14.13
[5] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.2**

FOCUS/DISPOSITION:

Scope

Aetna Better Health's Provider Complaint system offers a complaint resolution process when there is dissatisfaction between the participating provider, the Aetna Better Health or the plan's contracted vendors. Participating providers may file a complaint directly with Aetna Better Health verbally or in writing in regard to Aetna Better Health's policies, procedures or any aspect of the Aetna Better Health's administrative functions. Providers may consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint.[6]

In addition, participating and non participating providers may file a complaint directly with Aetna Better Health verbally or in writing in regard to Aetna Better Health's staff service or behavior, Aetna Better Health's contracted vendor staff or behavior, member behavior or dissatisfaction with the dispute resolution process. *See policy 6300.00.*

Aetna Better Health will make sure that no punitive action is taken against a provider who files a complaint. A dispute 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 complaints.[7]

Responsibilities

It is Aetna Better Health's policy that the resolution of issues regarding the interpretation of the LDH approved Aetna Better Health contract(s) is a matter solely between Aetna Better Health and the provider.

Aetna Better Health's Provider Relations representatives are available to discuss a provider's dissatisfaction of an issue covered by this policy, and if unable to satisfy the provider's inquiry, or if the provider remains unsatisfied with a dispute resolution, the provider complaint process will be offered.

[6] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 10.6.5.4**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.8.4**
[7] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.11**

Aetna Better Health will make sure the following requirements are met and that:

- A dedicated provider relations staff is available for providers to contact plan via telephone, electronic mail, surface mail, or in person, to ask questions, resolve disputes and to file a provider complaint.[8]
- Aetna Better Health will operate a provider access component of the toll-free telephone line to respond to provider calls
  - The provider access component of the toll-free telephone line will be staffed by Aetna Better Health provider representatives between the hours 7:00 am to 7:00 pm[9] (CDT) daily, excluding State holidays. Staff will answer the telephone help line and respond to provider questions in all areas, including but not limited to prior authorization, provider complaints, and provider responsibilities.
  - Aetna Better Health call center system will have the capability to track provider call management metrics.
- **Identify a key staff person specifically designated to receive and process provider complaints[10]**
- **Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and Network Provider Agreement provisions, collecting all pertinent facts from all parties and applying Aetna Better Health's written policies and procedures[11]**
- **Requests from LDH shall be acknowledged in writing within one (1) business day and addressed within five (5) business days, or within the time-period specified by LDH in the request;[12]**
- **Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be addressed within seventy-two (72) hours;[13]**
- **Requests from the LDH Provider Relations Unit shall be addressed within five (5) business days;[14]**

[8] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.5.1
[9] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 10.1.1
[10] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.5.2
[11] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.5.3
[12] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.2.1
[13] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.2.2
[14] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.2.3

- **If Aetna Better Health does not provide the requested information within the timeframes outlined above or in the LDH request, LDH may assess Monetary Penalties.[15]**

Complaint Committee

The Complaint Committee reviews complaint trends and may resolve issues related to an expression of dissatisfaction filed by providers including the complaint request and all supporting documentation. The committee is comprised of two (2) or more staff members, which may include but not limited to:

- Appeal and Complaint manager – chairperson (one (1) voting member as needed)
- Compliance officer (one (1) voting member as needed)
- Appeal and Complaint coordinator
- Officer of the plan who has the authority to require corrective action
- Representatives from Member Services, Provider Relations and Quality Management departments
- If clinical issue – Representative from Medical Management including by not limited to provider with same or similar specialty not involved in any prior decision making on the issue (one [1] voting member as needed)

As needed the voting members of the committee are assigned prior to each meeting. The voting panel will include individuals who were not involved in the complaint issue and who are not a subordinate to any person involved in the original complaint issue. The complaint case is presented to the committee and a resolution is rendered.

Communication of Complaint System Rights

Aetna Better Health will make the provider Complaint System processes available to the provider through the Provider Handbook and other mediums, including newsletters, training, provider orientation, the Aetna Better Health website, in hard copy upon request (at no charge to provider) or verbally when the provider calls the Provider Relations representative.[16]

[15] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.3
[16] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.9

Any updates and/or changes to currently approved provider complaint process will be submitted to LDH for approval prior to the implementation of the changes.[17] Aetna Better Health's provider complaint processes will remain unchanged during the LDH's review of new policies unless otherwise regarded by law.

Complaint Process

All Aetna Better Health staff who engage in provider contact must understand the procedures for receiving, documenting, and forwarding a provider complaint to the Appeal and Complaint department.

A trained and qualified Appeal and Complaint manager assumes primary responsibility for coordinating and managing provider complaints and for disseminating information to the provider about the status of the complaint.

Regardless of the department in which the information originates, all complaints are documented within Aetna Better Health's call system and submitted on the date of receipt, with supporting documentation, to the Appeal and Complaint department. The Appeal and Complaint coordinator documents the complaint in the Appeal and Grievance Application for tracking, review, referral, resolution, and reporting.

Providers may submit a complaint either verbally or in writing. Verbal submissions may be required to be committed to writing. Providers are allowed thirty (30) days from the date of the occurrence to file a written complant with Aetna Better Health.[18] Aetna Better Health will acknowledge all verbal requests verbally at the time of receipt and will acknowledge written requests either verbally or in writing within three (3) business of receipt.[19] The acknowledgment will include instruction on how to:

- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time until Complaint Committee review

The Appeal and Complaint department is designated to receive and process provider complaints. If the complaint requires research or input by another department, the Appeal and Complaint

[17] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.6**
[18] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 10.6.5.1
[19] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.7**

manager or their designee will forward the information to the affected department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions where as appropriate collecting pertinent facts from all parties and applying the Aetna Better Health's written policies and procedures. The provider is offered a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.[20] The complaint with all research will be presented to the Complaint Committee for decision.

The Complaint Committee will include a provider, with same or similar specialty if the complaint is related to a clinical issue, as well as an officer of the plan who has the authority to require corrective action.**[21]** The Complaint Committee will consider the additional information and will resolve the complaint.

Complaints will be reviewed and resolved within thirty (30) business days of receipt**[22] and providers have one hundred eighty (180) calendar days from date of denial to dispute our determination.**[23] The timeframe for resolution may not be extended. For all written requests, or requests where the provider requested a written response Aetna Better Health will generate a written notice to the provider within ten (10) calendar days from the date of the decision.

The Appeal and Complaint manager will review all data monthly for trends and reports trends to the Complaint Committee for review. All complaint data including volumes, categories and trends will be summarized and reported at least quarterly to Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC) for identification of opportunities for improvement as well as follow up on identified actions to address those opportunities.

Aetna Better Health will retain all appeal files in a secure, designated area for a period of at least ten (10) years following the final decision.

[20] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 10.6.5.7**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.8.7**
[21] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.8.6
[22] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.7
[23] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Amendment 2: 17 Attachment B

OPERATING PROTOCOL:

Systems

- Appeal and Grievance Application
- Aetna Better Health's call center system

Measurements

- The count of complaints received and resolved

Reporting

- Complaint Report(s) to LDH in the format and frequency specified by LDH[24]
- Complaint Report(s) to Medical Management and Quality Management Oversight Committee
- Management reports monthly and quarterly, or more often as directed
- Annual reports as applicable

INTER-/INTRADEPENDENCIES:

Internal

- Appeal and Complaint
- Provider Relations
- Executive director

External

- Network providers
- Out of network providers
- State and federal regulatory agencies

[24] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.10.9.8.10**

Aetna Better Health

Richard C. Born
Chief Executive Officer

Andre Greenwood~~Roger Gunter~~
Interim Chief Operating Officer