Aetna Better Health® of Louisiana

AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

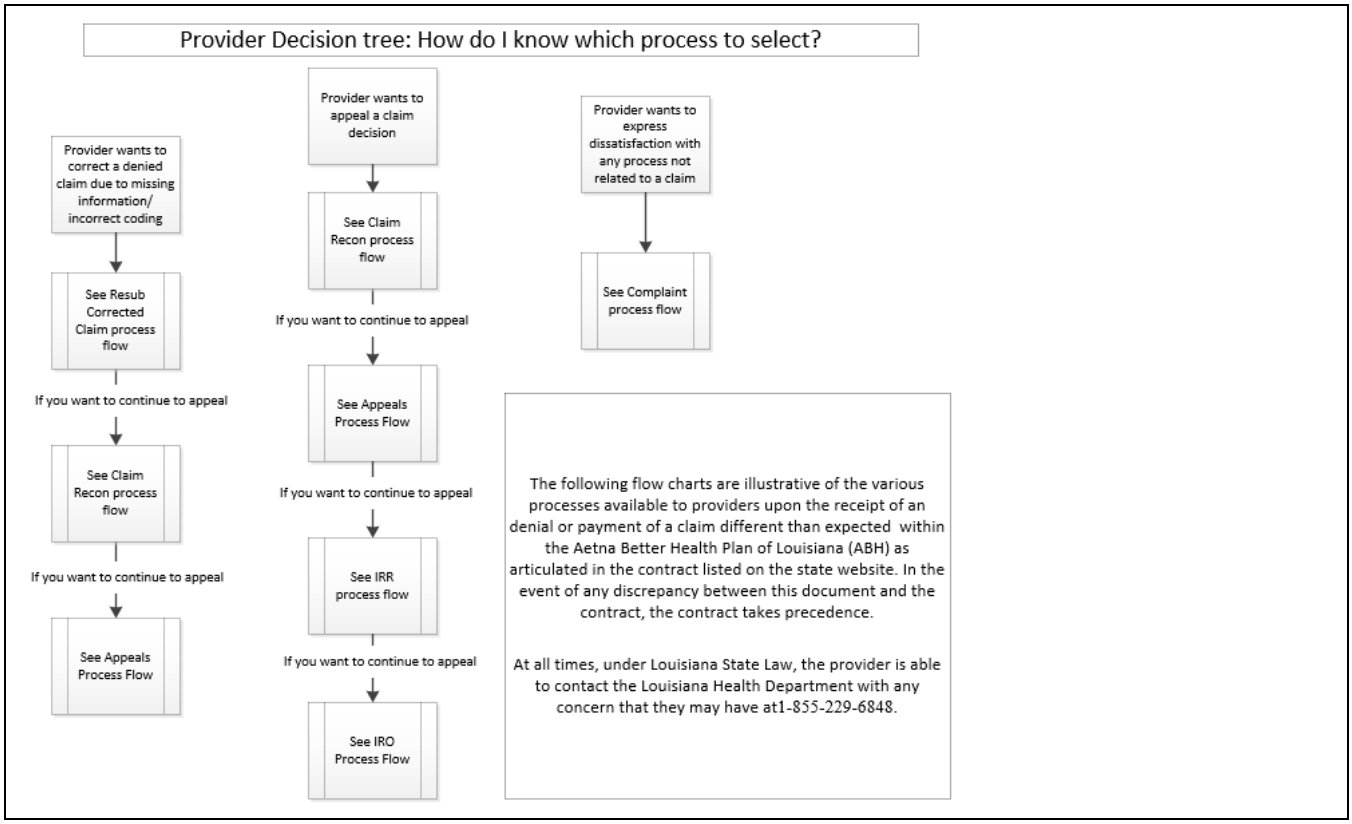
Policy

Policy Name:	Provider Adverse Determination Workflow	Page:	1 of 9
Department:	Administration	Policy Number:	ABHLA-RP-0001
Subsection:		Effective Date:	08/01/2018
Applies to:	Aetna Better Health of Louisiana		

PURPOSE:

Aetna Better Health of Louisiana is committed to partnering with Providers to resolve concerns resulting from claim denials or claim payment amounts. Aetna Better Health has prepared this Standard Operating Procedure to guide Providers through processes for their resubmissions, complaints, and appeals rights to ensure appropriate payments are made to providers for services provided to Aetna Better Health of Louisiana members.

STATEMENT OF OBJECTIVE/OVERVIEW:



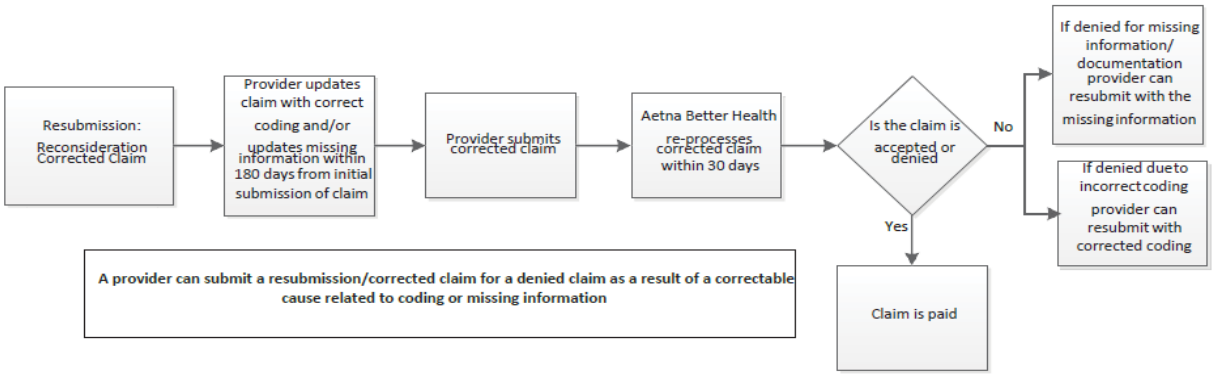
RESUBMISSION: CORRECTED CLAIM OR RESUBMISSION

Rendering providers may resubmit a claim within 180 days from the date of the original claim denial to:

1. Electronic Claims Submission: Aetna Better Health of Louisiana Payer ID: 128LA
2. Paper Claims Resubmissions:
   Aetna Better Health of Louisiana
   P.O. Box 61808
   Phoenix, AZ 85082-1808

Rendering providers also have the ability to resubmit claims that were denied for missing information such as an itemized bill, proof of timely filing, coordination of benefits information, claim or coding edit information (these items may also be called a reconsideration). For these resubmissions, providers must resubmit the claim with the missing information for reconsideration in writing, providers may be asked to complete the Provider Resubmission and Dispute form (located on our public website)

For paper resubmissions, please stamp or write one of the following on the paper claims AND on the envelope: CORRECTED CLAIM FOR RESUBMISSION



NOTE: Provider reconsideration does not include items related to medical necessity.

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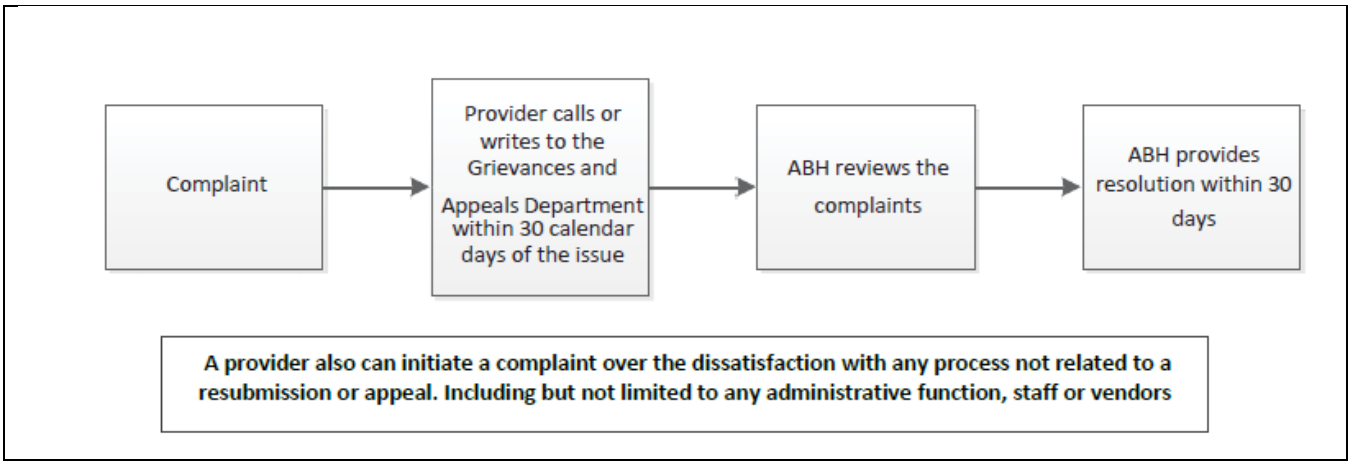
COMPLAINT

Provider complaints are expressions of dissatisfaction with any process not related to a Resubmission or Appeal including but not limited to any administrative function, ABH staff or contracted vendors. Rendering providers may file a verbal or written complaint with Aetna Better Health of Louisiana.

Providers can also file a verbal complaint by calling 1-855-242-0802.

To file a complaint in writing, providers should write to:
Aetna Better Health of Louisiana Grievance and Appeals Dept.
PO Box 81040, 5801 Postal Rd
Cleveland, OH 44181
FAX: 1-860-607-7657



CLAIM RECONSIDERATIONS AND APPEALS

Provider appeals are a request for review of a claim denial or payment that does not meet the criteria of a resubmission. The claim reconsideration is the first step of the appeal process.
Participating providers should follow the claim reconsideration followed by the appeals process:

- Provider must submit the claim reconsideration verbally or in writing, within 180 days of the remittance advice paid date. OR,
- If the claim reconsideration was upheld, the Provider must submit the appeal request in writing, via mail, fax, or online within 60 calendar days of the notice of denial.

AND

- Provide any additional or new clinical documents with the claim reconsideration or appeal.
- Aetna Better Health will take into account all documentation when rendering a decision on a claim reconsideration or appeal.
- When the claim reconsideration or appeal includes a medical necessity decision, it will be reviewed by the medical director who was not involved in the original denial
- A resolution letter will be mailed within 30 calendar days from receipt of the claim reconsideration or appeal
- Provider requests to appeal pre-service items on behalf of a member are considered member appeals and subject to the member appeal procedures and timeframes.

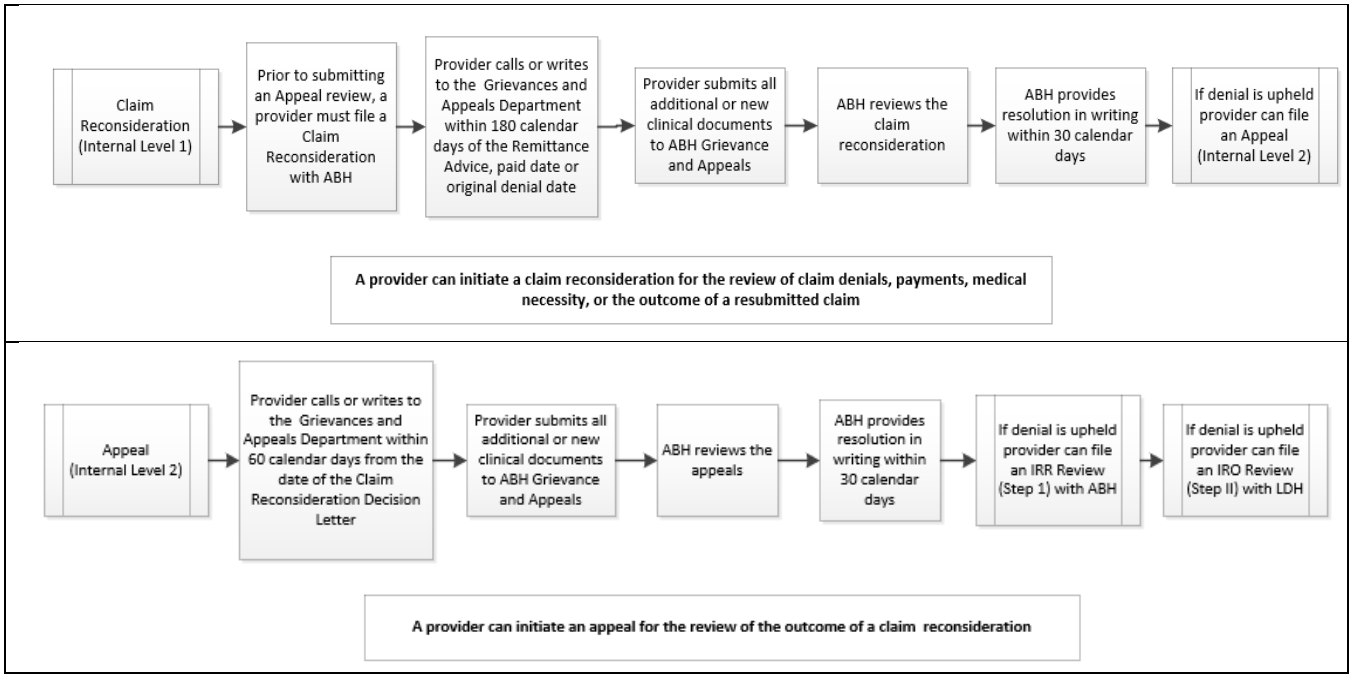
Rendering providers may file a written claim reconsideration or appeal with Aetna Better Health of Louisiana. Send the claim reconsideration or appeal request in writing to:
Aetna Better Health of Louisiana Grievance and Appeals Dept.
PO Box 81040, 5801 Postal Rd
Cleveland, OH 44181

Send the claim reconsideration or appeal via fax: (860) 607-7657 (Preferred Method)

Call Provider Services Department for oral claim reconsideration requests at: 1-855-242-0802

Submit a claim reconsideration or appeal online via the Availity provider portal:

1. Log into the Availity provider portal at https://apps.availity.com/availity/web/public.elegant.login.
2. Select **Payer Spaces** > **Aetna Better Health of Louisiana**.
3. Click **Medicaid Appeals**.
4. Complete the Appeals form, attaching all supporting information.
5. Click **Submit**.



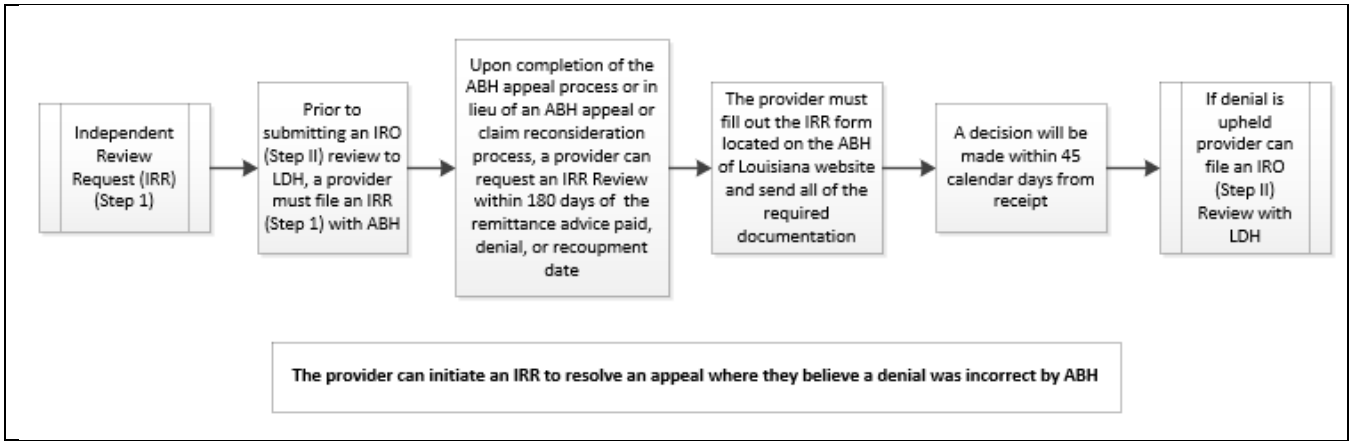
INDEPENDENT REVIEW

Independent Review is a two (2) step process which may be initiated by submitting an Independent Review Reconsideration (IRR) form to Aetna Better Health within 180 calendar days of the Remittance Advice paid, denial, or recoupment date.

The completed IRR form along with all required documents should be sent via mail or email to the following:
Aetna Better Health of Louisiana
Attn: Independent Review Reconsideration Request
PO Box 81040 5801 Postal Road
Cleveland, OH 44181
(Preferred method) Email: Independentreviewrequest@aetna.com

IRR Request forms can be found on the Aetna Better Health of Louisiana website below:

- https://www.aetnabetterhealth.com/louisiana/providers/index.html



If Aetna Better Health upholds the adverse determination, the provider may submit an Independent Review

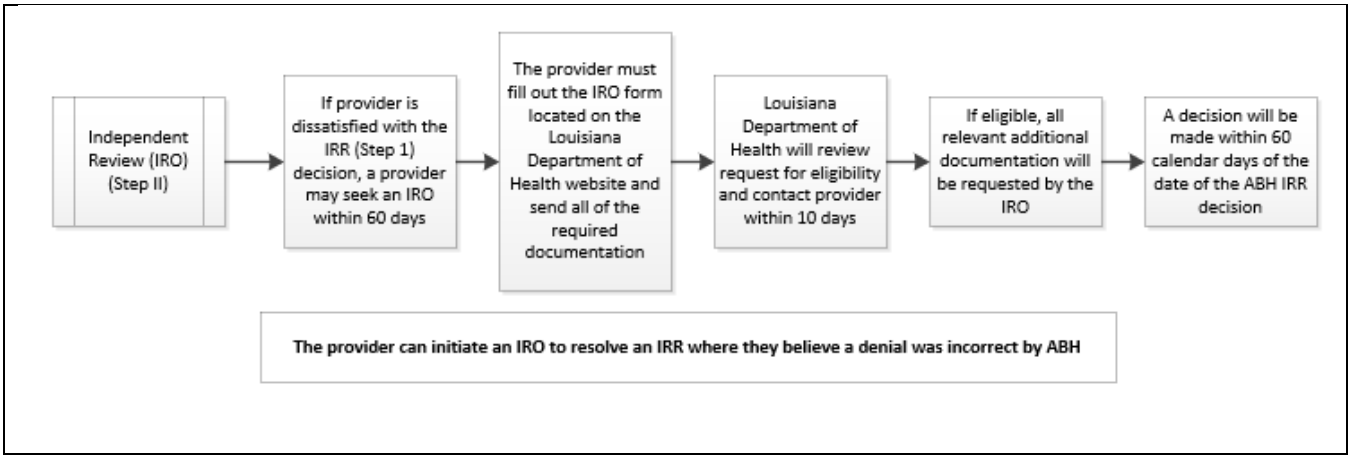
Request (IRO) to LDH, within 60 calendar days of Aetna Better Health's decision.

- LDH will determine eligibility for review and assign the independent review to an independent reviewer.
- The independent reviewer will contact the provider within 14 calendar days if eligible documentation is needed from the provider by the independent reviewer.
- The independent reviewer will render a decision within the time frames allowed per Act 349.

To submit a request for independent review, the provider must complete the LDH Independent Review Request form. The form can be found here:

- https://ldh.la.gov/page/2982

The independent review request (*after Aetna has made decision on your reconsideration request or 45 days after submitting the independent review reconsideration and no response has been received*) and completed request form along with all required documents (listed on the form) should be sent via certified mail to LDH at the following address:
LDH/ Health Plan Management
ATTN: Independent Review
PO Box 91030, Bin 24
Baton Rouge, LA 70821-9283



DEFINITIONS:

Resubmission	A resubmission is defined as request for Aetna Better health to reconsider the denial or payment amount on a claim that was originally denied because of incorrect coding or missing information such as an itemized bill, proof of timely filing, coordination of benefits information, claim or coding edit information that prevents Aetna Better Health from processing the claim. Practitioners and providers have 180 days from the initial remittance date to resubmit claims. Providers should also utilize the resubmission process anytime there is a change to the original claim.
Complaint	A provider complaint is defined as any expression of dissatisfaction by a provider, including complaints, about any matter other than an appeal, which is covered under the provider appeal process. Complaints may be about any subject including but not limited to: Administrative issues, Payment and reimbursement issues, Dissatisfaction with the resolution of a dispute, Aetna Better Health staff service or behavior or Vendor staff service or behavior
Claim Reconsideration Internal Step 1	A request by a provider for reconsideration of a partially or totally denied claim
Appeal Internal Step 2	An appeal is defined as a request for review of a claim denial or payment following a denied claim reconsideration. Please refer to the Aetna Better Health of LA Provider Manual, located on our website at https://www.aetnabetterhealth.com/louisiana for details.
Independent Review	A two (2)-step process established by La-RS 46:460.81, et seq. to resolve claims disputes when a provider believes a managed care organization (MCO) has partially or totally denied claims incorrectly. The belief that an MCO's failed to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial. Additional information regarding the independent review process can be found HERE.

Independent Review Reconsideration (IRR) (Step 1)	A request by a provider to resolve claims disputes when a provider believes Aetna Better Health has partially or totally denied claims incorrectly may submit an Independent Review Reconsideration to Aetna Better Health
Independent Review Organization (IRO) (Step II)	A request by a provider who remains dissatisfied with the outcome of an Independent Review Reconsideration Request may submit an Independent Review Request to LDH.
Arbitration	Provider has the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If Company and Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this Section shall be binding on all Parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless Company and Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the Parties. [RFP § 17.6.5]. A provider should review their contract with ABH for any specific language related to arbitration.

LEGAL/CONTRACT REFERENCE:

Informational Bulletin 19-03 – Medicaid Managed Care Provider Issue Resolution

Review/Revision History	
08/01/2018	Effective Date
03/07/2020	Updated logo, address, timeframes for appeals, and independent review section.
06/01/2021	Moved to new template.
02/03/2022	Updated EMR/IRO information