Aetna Better Health® Kids (CHIP)

Administrative Tools

Complaints, Grievances and Appeals Process

Time frames for filing member complaints, grievances and external review

- Complaints must be filed within 60 days of the encounter and will be eligible for one level of plan review. Complaints that fall within the 60 day window include:
  - A decision by the plan (non-covered services or post service claim payment)
  - The failure of the plan to provide services timely
  - The failure of the plan to decide a complaint or grievance timely
  - Post service claim denial of services provided without authorization by a provider not enrolled in the MA Assistance Program
  - Post service claim denial because the service or item is not a covered benefit
- Complaints regarding all other issues will have no limit on the time in which a member can submit a request for review. These complaints will be eligible for two levels of plan review.
- Grievances must be filed within 60 days of the date the member receives a written notice from the plan denying a service. Grievances will be eligible for one level of plan review:
  - Deny in whole or in part, payment for a service or item
  - Deny or issue a limited authorization of a requested service or item
  - Reduce, suspend, or terminate a previously authorized service or item
  - Deny the requested service or item but approve an alternative service or item
  - Deny a request for a benefit limit exception
- External review must be filed within 15 days of receipt of the written notice of the complaint or grievance decision. Refer to written notice for next level of appeal options.

Time frames for deciding complaints, grievances and external review

- Complaints must be decided and decision letters sent within 30 days of receiving the level 1 complaint and 45 days for level 2 complaint.
- Grievances must be decided and decision letters sent within 30 days of receiving grievance.
- External reviews will be decided within 60 days of filing the External Review Request.

Options after 1st level

- Complaints regarding denial of non-covered services, payment for services and failure of the plan to provide services or decide complaint or grievance can request an external review.
- Complaints for all other issues can request a 2nd level plan review.
- Grievances can request an external review.

Expedited reviews

Expedited reviews can be granted under the following circumstances:

- The plan determines the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be place in jeopardy by following the standard process.
- The member provides written certification from their provider the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be place in jeopardy by following the standard process.
- Decision must be issued within 48 hours of receiving the provider certification or 72 hours of receiving the member's request, whichever is shorter.
- If expedited review criteria is not met, the member will be notified of the decision to deny expedited review and decision will be made within the standard time frames.

Who can file

- Member – verbally or written
- Member's Parent, Guardian or documented Legal Representative – verbally or written
- Member's Provider or non-documented Representative – written authorization to act on member's behalf from the member must be supplied.

If you have any questions, please email Provider Experience at **ProviderRelationsPA1@Aetna.com** or call **1-866-638-1232**, option 1, then press the star key.