Provider Experience
Network Relations Team

Presenters
Kim Heggenstaller, Manager,
Network Relations

Bridget Paris, Senior Manager,
Complaints and Appeals

April 2022

Housekeeping

- All lines will be muted to reduce background noise
- Use the Q & A to submit any questions to ALL PANELISTS
- The presentation will be available on our website under Past Provider Education Webinars within a week and here is the link: https://www.aetnabetterhealth.com/pennsylvania/providers/education

Agenda

Provider Appeals and Disputes

- What is an Appeal?
- Steps to follow when submitting an appeal
- Appeal Trends and Reminders
- What is a Dispute?
- Appeal and Dispute Resolution
- Timeframes and Helpful Reminders
- Contact Information

Presenter: Bridget Paris

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Provider Appeals & Disputes

What is an Appeal?

An appeal is a formal post service expression of dissatisfaction in which a provider requests that ABH change an adverse determination for care or services rendered to a member.

When submitting an appeal, be sure to:

1. Use the Appeal Form to submit your appeal in writing to the appeals department

2. State the factual basis for the relief requested.

3. Include all supporting documentation with the appeal, such as claim number, medical records, office notes, operative notes, remittance advice and any other substantial documentation.

IMPORTANT: Failure to specifically state the factual basis of the appeal and/or failure to submit supporting documentation may result in denial of the provider appeal. The Provider Clinical Appeals committee reviews all appeals and makes the final determination.

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What is a Dispute?

A dispute is a verbal or written expression of dissatisfaction concerning a decision that directly impacts the provider. Disputes are typically administrative and do not include decisions concerning medical necessity. Formal provider disputes must be received in writing.

Disputes can be resolved through multiple avenues such as:

- ABH Secure Web Portal
- Availity Portal
- Claim Inquiry and Claims Research (CICR)
- Network Relations Consultant (assigned provider rep)

Appeal Submission Trends and Reminders

- Medical Records submitted to the appeals department without a letter or appeal form
- Status/Follow up requests for decision letters - The mailing address to return the appeal determination must be supplied with each appeal if it is different than the address on file.
- Requests from providers for 2nd Level provider Appeals – 1st Level Appeal decision is final
- Provider request for Grievance review of Prior Authorization Denials – written consent of the member is required for all requests:
  - Requests without written member consent are pended for 30 days and a *Consent for Provider to File a Grievance for Member Form* is sent to the member
  - The Appeal Review **cannot be started** until written member consent is received
    - If consent is received, the case will be started for review which could take up to 30 days
    - If consent is not received, the case is closed as ineligible for review

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Appeal Timeframes

Appeal Filing
Appeals must be received within (60) days of claim notification.

Acknowledgement
ABH will send acknowledgement within (5) business days of receipt.

Appeal Decision
A decision will be rendered within (60) calendar days after receipt.

Appeal Extensions
ABH may request an extension of up to (30) calendar days, if necessary.

Decision Letters
ABH sends letters within (5) business days after a committee decision is made.

*Timeframes may vary depending on terms of the provider contract.

Appeal Reminders

Submit post appeal claim review appeals to Cotiviti and/or Equian address when applicable If the appeal is upheld, the provider can then file a formal appeal to the plan.

Ensure that provider addresses are legible and accurate on the appeal letter so that responses can be sent to the correct address.

Ensure that the contract in place for the date of service in question aligns with the appeal request.

Utilize the P2P process for pre-service denials. If the P2P timeframe is missed, a new prior authorization request form with the additional information required can be sent.

ABH is required to follow up with providers on claim denials notices submitted to the plan as member complaints.

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Miscellaneous Contact Information

Claims & Corrected Claims Mailing Address

Aetna Better Health of PA
PO Box 62198
Phoenix, AZ 85082-2198

Equian

Equian Claims Resolution
600 12th Street, Suite 300
Golden, CO 80401

Claims Inquiry Claims Research (CICR) for Claim Inquiries

Provider Services Phone Unit
866-638-1232

Prior Authorization Department

Phone 866-638-1232
Fax 877-363-8120

Prior Auth Search Tool
Prior Auth Checklist

Cotiviti Clinical DRG Reviews

Aetna Better Health Cotiviti
Clinical Chart Validation
Hillcrest II Building
731 Arbor Way, Suite 150
Blue Bell, PA 19422

Fax (less than 75 pages)
203-529-2778

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Appeals Contact Information

Aetna Better Health

ATTN: Appeals Department

PO Box 81040

5801 Postal Road

Cleveland, OH 44181

Fax

860-754-1757

Email

PAMedicaidAppeals&Grievance@AETNA.com

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As a team, we are committed to supporting our providers and working together toward positive outcomes for your patient, our member.

— YOUR PROVIDER EXPERIENCE TEAM —

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Our Providers and Members Our Priority

Your Time is valuable.

Aetna Better Health of Pennsylvania Works to Serve Your Practice.

Provider Customer Service 1-866-638-1232

All Credentialing and Roster Up-Dates

MedicaidProviderRelations@AETNA.com

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Thank you for joining us today!