Provider Dispute, Appeal and Grievance Instructions

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULL REGARDING DISPUTED CLAIM DENIAL AND DISPUTED CLAIM PAYMENT AMOUNTS AND FOLLOW THE INSTRUCTIONS INDICATED

A **dispute** is defined as an expression of dissatisfaction with any administrative function including policies and decisions based on contractual provisions inclusive of claim disputes. The dispute will be reviewed and processed according to the definitions in this document, including by not limited to resubmissions (corrected claims and reconsiderations), appeals, complaints and grievances. Provider claim disputes do not include preservice disputes that were denied due to not meeting medical necessity. Preservice denials are processed as member appeals and are subject to member policies and timeframes.

A **resubmission** is a request for review of a claim denial or payment amount on a claim originally denied because of incorrect coding or missing information that prevents Aetna Better Health of Virginia from processing the claim.

Corrected claim

- Submit a corrected claim marked at the top of the claim "CORRECTED CLAIM FOR RESUBMISSION," along with the completed *Provider Dispute and Resubmission Form*, found on the last page.

Examples of a corrected claim:
Newly added modifier
Code changes
Any change to the original claim

Reconsideration

- Submit a claim form marked at the top "RECONSIDERATION," along with the completed *Provider Dispute and Resubmission Form*, found on the last page.
- Submit medical records and/or additional information required to reconsider the claim.
- Information should be submitted **single-sided**.
- Please refer to the provider manual for provider filing timeframes.

Examples of reconsiderations:
Itemized Bill • All claims associated with an itemized bill must be broken out per rev code to verify charges billed on the UB match the charges billed on the itemized bill. (Please attach itemized bill that is broken out by rev code with sub-totals.)
Duplicate Claim • Review request for a claim whose original reason for denial was "duplicate." • Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed.

Retro Authorization Request • Claims that were denied due to no authorization on file; medical records must be included with the resubmission.
Coordination of Benefits • Attach EOB or letter from primary carrier.
Proof of Timely Filing • For electronically submitted claims provide the second level of acceptance report   o Refer to *Proof of Timely Filing Requirements* in the Provider Manual.
Claim/Coding Edit • We use two claims edit applications: Claim Check and Cotiviti.   o Refer to the Provider Manual for details.

All claim disputes (resubmitted claims with corrections or missing information for reconsiderations) must be submitted to:

Aetna Better Health of Virginia
Attn: Reconsiderations
PO Box 982974
El Paso, TX 79998-2974

An appeal is a request for review of a claim denial or payment that does not meet one of the items above. Please refer to the Aetna Better Health of Virginia Provider Manual, located on our website at **www.aetnabetterhealth.com/virginia** for details.

Examples of appeals:
Requests for review on your own behalf
Untimely Filing of the Claim • A review of a claim that was submitted outside the timeframe • Provide good cause justification documentation for late filing **or** for electronically submitted claims, provide the second level of acceptance report as proof of timely filing.   o Refer to *Proof of Timely Filing Requirements* in the Provider Manual.
Untimely Decision Making • A review of a decision where Aetna did not render the decision on a prior authorization timely • Provide a copy of the denial showing the received date and the decision date.
Dissatisfaction with the resolution of a reconsidered disputed claim
Dissatisfaction with a claim payment amount or claim denial based on a fee schedule or contractual issue
For Medicare Plans: **Noncontracting providers have the right to appeal a denied claim or amount paid on the claim.** • Send a written notification of your request with the claim number. • Include any additional information, including clinical records or other documentation. • If the claim was denied: Include a signed *Waiver of Liability Form*. • If you disagree with the payment amount, include evidence that the claim would have been paid differently under original Medicare.
On Behalf of a Member

- Continued stay concurrent review
- Urgent or emergent review
- Preservice (prior authorization) requests
    - Must have written consent to act on behalf of the member.
- When filing on behalf of a member, the request is processed as a **member appeal** and is subject to the member appeal policies and timeframes.

A **GRIEVANCE** is an expression of dissatisfaction not related to a request for Aetna to reconsider our decision on the denial of a claim or the payment on a claim. Please refer to the Aetna Better Health of Virginia Provider Manual, located on our website at https://www.aetnabetterhealth.com/virginia/ for details.

Examples of Grievances:
• Dissatisfaction with administrative functions or policies • Vendor staff service or behavior • Aetna Better Health staff behavior
On Behalf of a Member • When filing on behalf of a member, the request is processed as a **member grievance** and is subject to the member appeal policies and timeframes

If any of the above appeal or grievance examples apply, **DO NOT** use the *Dispute and Resubmission Form*. Please **fax** or **mail** the appeal or grievance and all supporting documentation clearly marked as "FILING AN APPEAL" or "FILING A GRIEVANCE" to:

Aetna Better Health of Virginia
Attn: Reconsiderations
PO Box 982974
El Paso, TX 79998-2974

Provider Dispute and Resubmission Form

Please complete the information below in its entirety and mail with supporting documentation to the designated address. Incomplete or missing information may result in your dispute being returned or decision upheld.

Select the appropriate reason	
□ Incorrect Denial of Claim or Claim Line(s)	□ Medical Necessity
□ Incorrect Denial of Authorized Service	□ Incorrect Rate Payment
□ Code or Modifier Issue	□ Other _____

Your Dispute Must Include:

- This completed form
- Copy of the original claim
- Any additional information (clinical records, required documentation, CMS or Medicaid references as needed, copy of authorization, etc.)

Provider Name:	
Provider NPI:	
Submitter's Name:	
Provider Phone Number:	
Date(s) of Service:	
Claim Number(s):	
Member Name:	
Member ID:	

Please indicate the specific reason for your request and any pertinent details below:

_____ _____

Signature of Sender Date