AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Provider Appeals and Claim Reconsiderations	Page:	1 of 16
Department:	Appeal and Grievance	Policy Number:	6300.38
Subsection:		Effective Date:	12/30/2015
Applies to	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to describe Aetna Better Health's obligations regarding a provider's right to file an appeal or claim reconsideration. Aetna Better Health has established a provider appeal and claim reconsideration process that provides for the prompt and effective resolution of appeals and claim reconsiderations between the health plan and providers. This system is specific to providers and does not replace the ~~enrollee~~member appeal and grievance system which allows a provider to submit an appeal on behalf of a ~~enrollee~~member. When a provider submits an appeal on behalf of a ~~enrollee~~member, the requirements of ~~enrollee~~member appeal and grievance system will apply.

STATEMENT OF OBJECTIVE:

The objectives of this policy are to:

- Define the procedure for participating healthcare providers and non-participating providers to use when filing an appeal or claim reconsideration
- Facilitate compliance with federal and state laws and rules and state contractual requirements for the provider appeal and claim reconsideration process
- Promote effective management of provider appeals and claim reconsiderations
- Provide for accurate maintenance of required documentation
- Maintain compliance with reporting requirements

DEFINITIONS:

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.
Independent Review Reconsideration (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.
~~Enrollee~~Member Appeal	A ~~enrollee~~member or ~~enrollee~~member representative's request for review of an adverse benefit determination, as defined in this policy.

	There are multiple types of ~~enrollee~~member appeals; pre-service appeals, post-service appeals, expedited appeals and State fair hearings.
~~Enrollee~~Member Expedited Appeal	A request by ~~enrollee~~member or their representative for fast review and reconsideration of a decision with respect to an adverse benefit determination, ~~-~~when the time periods for making a non-clinically urgent determination could seriously jeopardize the ~~enrollee~~member's life, health or the ability to attain, maintain or regain maximum function, or in the opinion of the treating provider ~~enrollee~~member's condition cannot be adequately managed without the urgent care or services. **All expedited provider appeals are processed as ~~enrollee~~member appeals, and therefore subject the requirements of the ~~enrollee~~member appeal policy.**
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 ~~[PLAN]~~Aetna Better Health and is not credentialed by ~~[PLAN]~~Aetna Better Health.
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 a ~~[PLAN]~~Aetna Better Health and who participates in ~~[PLAN]~~Aetna Better Health's provider network or an individual or facility that is subcontracted by ~~[PLAN]~~Aetna Better Health to serve Aetna Better Health~~[insert program name]~~ ~~enrollee~~members.
Post-Service Appeal	A post-service appeal is a request to change an adverse determination for care or services that have already been rendered.
Pre-Service Appeal	A pre-service appeal is a request to change an adverse determination made by the health plan related to benefit coverage in advance of the ~~enrollee~~member obtaining the care or services.
Provider Appeal (Internal Level 2)	A request by provider to appeal actions of the health plan when the provider:

	• Has a claim for reimbursement, or request for authorization of service delivery, denied or not acknowledged with reasonable promptness • Has a claim that has been denied or paid differently than expected. An appeal is the formal process for resolving provider claim reconsiderations. • Appeals must be requested within ~~[~~sixty (60) calendar days~~-~~ of the date on the determination letter from the original request for claim reconsideration. **Requests to appeal postservice items are always on behalf of the provider and considered a provider appeal subject to the timeframes and procedures in this policy. They are not eligible for expedited processing.** **Requests to appeal pre-service items on behalf of the ~~enrollee~~member are considered ~~enrollee~~member appeals and subject to the ~~enrollee~~member appeal timeframes and policies.**
Provider Appeal and Complaint~~Grievance~~ System	The process in which the provider is able to file a claim reconsideration or~~an~~ appeal and the system for documenting and tracking claim reconsiderations and appeals~~-~~ and their resolutions.
Provider Claim Reconsideration (Internal Level 1)	A request by a provider for reconsideration of a partially or totally denied claim
Remittance Advice	Written notification send to the provider with claim payment or claim denial information that explains next level rights.
State Agency Name and Acronym	Louisiana Department of Health (LDH)
Timelines	A provider may file a claim reconsideration within one-hundred eighty (180) days from the date of the remittance advice. A provider may file

	an appeal within sixty (60) calendar days from the date on the determination letter from the original request for claim reconsideration. The organization makes decisions within thirty [forty-five (3045) calendar days- of receipt of the provider appeal or claim reconsideration.

LEGAL/CONTRACT REFERENCE:

- 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 17.6.5
- LA R.S. §460.82
- State and federal rules and regulations
- 42 C.F.R. § 438.400 – 438.424

FOCUS/DISPOSITION:

Scope

Aetna Better Health's provider Appeal and Complaint system offers an impartial process for resolving provider requests to reconsider a decision. A provider may file an appeal or claim reconsideration with Aetna Better Health. Aetna Better Health will respond to provider appeals and claim reconsiderations pursuant to the guidelines in this policy. Upon completion of or in lieu of the Aetna Better Health claim reconsideration or appeal process, the provider can file an Independent Review Reconsideration Independent Review Reconsideration appeal with Aetna Better Health.

Aetna Better Health will make sure that no punitive action is taken against a provider who files a claim appeal or claim reconsideration. An appeal or claim reconsideration between a provider and Aetna Better Health will not disrupt or interfere with the provisions of services to the enrolleemember. Aetna Better Health will administer an equitable, timely, and balanced review of provider appeal or claim reconsideration.

Responsibilities

It is Aetna Better Health's policy that the resolution of issues regarding the claim denial or claim payment amount that were not resolved through the dispute process as defined in Policy 6300.00 is a matter covered by this policy. Aetna Better Health will inform providers about this policy through the Provider Handbook and other mediums, to include newsletters, training, provider

orientation, the website, and by the provider calling their Provider Relations representative. Aetna Better Health's Provider Relations representatives are available to discuss a provider's concerns regarding any issue covered by this policy.

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 appeal or claim reconsideration.
- 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 of 7:00 a.m.to 7:00 p.m. (CT) 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 appeals, provider claim reconsiderations and provider responsibilities.
  - Aetna Better Health call center system will have the capability to track provider call management metrics.

Appeal Committee

The Appeal Committee is responsible for reviewing appeal and claim reconsideration trends and may be responsible for reviewing appeal and claim reconsideration requests 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)
- Compliance officer (one [1] voting member)
- Chief medical officer or designated medical director (one [1] voting member)
- Representatives from Quality Management and Utilization Management departments
- If clinical issue – staff RN
- If clinical issue – physician with same or similar specialty

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 original decision and who are not a subordinate to any person involved in the original decision. When reviewing cases the

committee takes into account all documentation received as part of the original denial and with the appeal. Chief medical officer (CMO) or designated medical director takes a vote and renders the final decision.

Communication of Appeal and Complaint System Rights

Aetna Better Health will make the provider Appeal and Complaint System processes available to the provider through the Provider Handbook and other mediums, including newsletters, training, provider orientation, the remittance advice, 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.

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

Appeal and Claim Reconsideration Process

All ~~[PLAN]~~Aetna Better Health staff who engage in provider contact must understand the procedures for receiving, documenting, and forwarding a provider appeal or claim reconsideration to the Appeal and Complaint department.

Provider appeals and claim reconsiderations include requests to appeal or reconsider postservice items. They are always on behalf of the provider and subject to the timeframes and procedures in this policy. They are not eligible for expedited processing. Any request to appeal a pre-service item is considered to be on behalf of the ~~enrollee~~member and subject to ~~enrollee~~member appeal timeframes and policies. Providers must have written consent to act on behalf of the ~~enrollee~~member. If a pre-service authorization request was submitted and denied followed by~~ut~~ a claim submission that was denied, the appeal or claim reconsideration will be considered a provider appeal or claim reconsideration and subject to the timeframes and procedures in this policy.

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

Regardless of the department in which the information originates, all appeals and claim reconsiderations 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 appeal, -claim reconsideration, Independent Review Reconsideration, IRO or Arbitration case in the Appeal and Grievance Application for tracking, review, referral, resolution, and reporting.

Providers or their authorized representative may submit a claim reconsideration request verbally in or writing within one hundred eighty (180) calendar days of the Remittance Advice paid date or original denial date to the following address:

Aetna Better Health of Louisiana
Attn: Claim Reconsiderations
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Phone: 1-855-242-0802

A provider's request for claim reconsideration is required before requesting a provider claim appeal. Providers or their authorized representative have the option to submit an appeal following the claim reconsideration process. The provider must submit any documentation from the claim reconsideration request when submitting a provider appeal.

Providers must submit an appeal request in writing within sixty (60) calendar days from the date of the Claim Reconsideration Decision Letter to the following address:

Aetna Better Health of Louisiana
Attn: Appeals Department
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Aetna Better Health will acknowledge all requests ~~written requests either verbally or~~ in writing within ~~[~~five~~three~~ (5~~3~~) calendar days of receipt. The acknowledgment will include instruction on how to:

- Revise the appeal or claim reconsideration within the timeframe specified in the acknowledgement letter
- Withdraw an appeal or claim reconsideration at any time until Appeal Committee review

The Appeal and Complaint department is designated to receive provider appeals and claim reconesiderations, documenting the substance of individual appeals and claim reconsiderations, coordinating resolutions, tracking data and reviewing appeals and claim recon~~d~~siderations for trends in quality of care or other service related issues. If the appeal or claim reconsideration requires research or input by another department, the Appeal and Complaint department will forward the information to the affected department and coordinate with the affected department to thoroughly research each appeal or claim reconsideration 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 appeal or claim reconsideration with all research will be presented to a medical director or to the Appeal Committee for decision. For cases that go to the Appeal Committee, the committee will also include an officer of the plan who has the authority to require corrective action.

Aetna Better Health will confirm that the individual(s) who make decisions on appeals and claim reconsiderations either individually or through Appeal Committee are individual(s) who were not involved in any previous level of review or decision-making and if deciding an appeal or claim reconsideration of a denial, reduction, termination or suspension that is based on lack of medical necessity or an appeal or claim reconsideration that involves other clinical issues are health care professionals with same or similar specialty who have the appropriate training and clinical expertise, as determined by the state agency, in the field of medicine treating the ~~enrollee~~member's condition or disease or who has experience treating the ~~enrollee~~member's condition or disease or treating similar complications related to the ~~enrollee~~member's condition or disease.

- Clinical appeals and claim reconsiderations are conducted by health professionals who:
  - Are clinical peers
  - Would typically manage the medical, procedure, or treatment in their practice that is the subject of the appeal or claim reconsideration

- Hold an active, unrestricted license to practice medicine or a health profession;
- Are board-certified (if applicable) by:
  - A specialty board approved by the American Board of Medical Specialties (doctors of medicine)
  - The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine)
- Chiropractic appeals or claim reconsiderations will be reviewed by a chiropractor

- Aetna Better Health will appoint at least one (1) person to review the appeal or claim reconsideration who is a practitioner in the same or a similar specialty as typically manages the medical, procedure, or treatment in question in the appeal or claim reconsideration. All same specialty review recommendations are presented to the appropriate person, persons or department as part of the appeal or claim reconsideration investigation**.**

A Medical Director will consider the additional information and will decide the appeal or claim reconsideration.

Appeals and claim reconsiderations will be reviewed and resolved within thirty (30) calendar days of receipt. ~~The decision on verbal requests for appeal will be communicated to the provider via telephone no later than [three (3) business days / insert state specific timeframe if none or different] after the decision is made.~~ For all ~~written~~ requests, ~~or requests where the provider requested a written response~~ Aetna Better Health will generate a written decision notice to the provider via electronic mail, fax or surface mail within three (3) business days from the date of the decision and within the original thirty (30) calendar day timeframe~~as promptly as the enrollee's health requires~~. The timeframe for resolution may not be extended.

The Appeal and Complaint department staff reports to the chief operating officer (COO). All data collected is reported to the Appeal Committee, Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate) summarizing the frequency and resolution of all appeals and claim reconsiderations 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 and claim reconsideration files in a secure, designated area for a period of at least ten (10) years following the final decision.

Independent Review Process

Upon completion of the Aetna Better Health appeal process or in lieu of an Aetna Better Health appeal or claim reconsideration process, a provider can request an Independent Review. The Independent Review is a two (2) step process.

Independent Review is another avenue for providers to resolve claim disputes when they believe Aetna Better Health has partially or totally denied a claim incorrectly. The Independent review allows providers an opportunity to have the denied claim(s) reviewed by an impartial third party. Aetna Better Health's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within sixty (60) days of Aetna Better Health's receipt of the claim is considered a claims denial.

The types of claims eligible for independent review are as follows:

- Claims billed to Aetna Better Health after January 1, 2018.
- Claims denied in whole or in part by Aetna Better Health.
- Claims where Aetna Better Health recouped monies remitted for a previously paid claim.
- Claims where the provider did not receive a notice from Aetna Better Health either partially or totally denying the claim.
- Claims where Aetna Better Health recouped monies from a mental health rehabilitation service provider as a result of a finding of waste or abuse~~fraud~~.[1]

- Claims involved in arbitration or litigation **cannot** be sent to independent review.

Request for Independent Review Reconsideration~~Appeal through the State Agency~~

Step 1 – Request an independent review reconsideration with Aetna Better Health

[1] LOUISIANA REVISED STATUTES TIT. 46, §460.81

An IRR may be initiated by submitting an Independent Review Reconsideration Request Form to Aetna Better Health within one hundred eighty (180) calendar days of the Remittance Advice paid, denial, or recoupment date. Prior to submitting an independent review to LDH, the provider must submit a request for independent review reconsideration (IRR) to Aetna Better Health within one hundred eighty (180) days from one of the following dates:

- Date on which Aetna Better Health transmits remittance advice or other notice of claim denial.
- Sixty (60) days from the date the claim was submitted to Aetna Better Health if the provider receives no notice from Aetna Better Health either partially or totally denying the claim.
- Date on which Aetna Better Health recoups monies remitted for a previously paid claim.

Aetna Better Health will acknowledge in writing its receipt of the IRR request within five (5) calendar days after receipt of the request.

Aetna Better Health renders a final decision of the IRR request within forty-five (45) calendar days from the date of receipt, unless another time frame is agreed upon in writing by the provider and Aetna Better Health.

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

- https://www.aetnabetterhealth.com/louisiana/providers/index.html
- http://ldh.la.gov/assets/HealthyLa/IndependentReview/IRRForm.pdf

The completed request 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
2400 Veterans Memorial Blvd. Suite 200
Kenner, LA 70062
(Preferred method) Email: Independentreviewrequest@aetna.com

If for some reason an IRR form is not used, the IRR request must clearly state that it is a request for independent review reconsideration.

Request for Independent Review throught the State Agency

Step 2 – Request an independent review with LDH

If Aetna Better Health upholds the adverse determination, or does not respond to the IRR request within the forty-five (45) calendar days allowed, the provider may then submit the independent review to LDH.

- LDH must receive the independent review request within either:
  - Sixty (60) days of the date the provider received Aetna Better Health's decision of the IRR request; or
  - If the provider does not receive a decision within the forty-five (45) calendar day time frame, sixty (60) days from the last day of the time frame. (105 days from the date the IRR request was submitted to Aetna Better Health.)

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 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
P.O. Box 91030, Bin 24
Baton Rouge, LA 70821-9283
Attn: Independent Review

Medical records should not be sent to LDH. The independent reviewer will contact the provider and Aetna Better Health to obtain all pertinent documents. Within ten (10) business days of receipt of the request, LDH will notify the provider (via email) of the status of the review. If the provider does not receive a notification from LDH within the above time frame, the provider should email IndependentReview@la.gov -to inquire about the status of the review.

Upon receipt of an independent review, LDH screens the request to ensure all steps of the process were followed in the appropriate time frames.

All required documents must be submitted with the request for independent review. If a required document is not included, LDH will contact the provider and request the missing document(s). If LDH does not receive the document(s) timely, the independent review will be marked as ineligible. If LDH determines that the request is ineligible for independent review, a notice will be emailed to the provider with an explanation as to why the request is ineligible.

A provider may aggregate multiple adverse determinations when the specific reason for nonpayment of the claims involve a dispute regarding a common substantive question of fact or law.

- The sole fact that a claim is not paid does not create a common substantive question of fact or law, unless no remit advice was received either partially or totally denying the claims.

The independent reviewer makes the final determination as to whether claims are eligible for aggregation. If a provider elects to aggregate its claims, the independent reviewer may, upon request, allow for up to an additional thirty (30) days for both the provider and Aetna Better Health to provide relevant information related to the independent review requests. If a reviewer determines that claims should not have been aggregated, a fee will be assessed for each claim that cannot be aggregated, and the reviewer will provide their reasoning for the determination.

Within fourteen (14) calendar days after the independent reviewer receives a new case, they will contact the provider and Aetna Better Health, via email, to request all supporting information and documentation regarding the disputed claim(s). The provider and Aetna Better Health must provide all information to the independent reviewer within thirty (30) calendar days of the request. The independent reviewer will not consider any information or documentation not received within the thirty (30) day time frame.

Once the reviewer has completed their review, they will send out the final decision (via email) to the provider, Aetna Better Health, and LDH.

If the independent reviewer renders their decision in favor of Aetna Better Health:

- Within ten (10) days of the final decision, the provider shall reimburse Aetna Better Health the $750 independent review fee.
- If the provider fails to submit payment for the independent review, Aetna Better Health may withhold future payments to the provider in an amount equal to the cost of the independent review and LDH may prohibit the provider from future participation in the independent review process.
- Aetna Better Health will provide specific instructions on how to submit payment.

If the independent reviewer renders their decision in favor of the provider:

- Within twenty (20) calendar days of the final decision, Aetna Better Health shall send the provider payment in full along with twelve percent (12%) interest calculated back to the date the claim was originally denied or recouped.
- If the provider does not receive the payment within twenty (20) calendar days of the final decision, the provider should notify LDH by sending an email to IndependentReview@la.gov.

Within sixty (60) calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Any claim concerning an independent reviewer's decision not brought within sixty (60) calendar days of the decision shall be barred indefinitely.

Any questions regarding the independent reviewer's final decision should be submitted directly to LDH at IndependentReview@la.gov.

OPERATING PROTOCOL:

Systems

- All appeals and claim reconsiderations are entered and tracked in the Appeal and Grievance Application
- ~~Enrollee~~Member, claims, and call information is available from the ~~[PLAN]~~Aetna Better Health business application system

Measurement

- Total volume of appeals and claim reconsiderations by type and reason
- Total volume of appeals and claim reconsiderations adjudicated within regulatory time frames
- Appeal turn-over rates by volume and type

Reporting

- Appeal and Claim Reconsideration Report(s) to LDH in the format specified by LDH
- Appeal and Claim Reconsideration Report(s) to Medical Management and Quality Management Oversight Committee
- Management reports monthly and quarterly, more often as directed
- Annual reports as applicable

INTER-/INTRADEPENDENCIES:

Internal

- Appeal and Complaint
- Claims
- Medical Services
- ~~Enrollee~~Member Services
- Provider Relations
- Quality Management

External

- Practitioners
- Providers
- State regulatory agency

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Richard C. Born
Chief Executive Officer

Roger Gunter
Chief Operating Officer

Review/Revision History	
01/2016	Reviewed and revised
02/2017	Reviewed and revised
11/2017	Reviewed and revised
07/2018	Updated to current template, updated signatories, and added Independent Review process to reflect current contractual requirements
06/2019	Reviewed, updated to current template, changed hours to 7a – 7p
07/2019	Review and revised
05/2020	Updated to current template. Reviewed and revised
11/2021	Annual Review. Updated to AMA template. Added reconsideration process to reflect current contractual requirements and updated the IRO process