



Practitioner/Provider Appeal Process

This document gives practitioners and providers instructions for appealing an adverse decision, including when and how to submit a dispute. This information applies to all Aetna medical benefits plans. State requirements will take precedence where they differ from Aetna's policy.

DEFINITIONS

For the purposes of our appeal process, the following definitions apply:

Practitioners are individuals or groups who are licensed or otherwise authorized by the state in which they provide health care services to perform such service. Examples include physicians, podiatrists and independent nurse practitioners.

Providers are institutional providers and suppliers of health care services. Examples include hospitals, skilled nursing facilities and behavioral health organizations, such as mental health or residential treatment facilities.

Dispute is a disagreement regarding a claim or utilization review decision.

Reconsideration is a formal review of a previous claim payment decision or a claim that requires reprocessing.

Level 1 Appeal is an oral or written request by a practitioner/provider to change either an adverse reconsideration decision or adverse initial utilization review decision. Practitioners and providers may request Level 1 Appeals.

Claims Issues relate to all decisions made during the claims adjudication process (for example, related to the provider contract, our claims payment policies, processing error, etc.), as well as decisions made as a pre-determination of services not requiring precertification.

Utilization Review Issues relate to decisions made during the precertification, concurrent or retrospective review processes (services requiring precertification). For these types of issues, the Practitioner/Provider Appeal Process only applies to appeals received subsequent to the services being rendered. The member appeal process applies to appeals related to pre-service or concurrent medical necessity decisions.

Level 2 Appeal is an oral or written request by a practitioner to change a Level 1 Appeal decision. Generally, only practitioners may request a Level 2 Appeal; however, in some states providers may have a second level of appeal.

PRACTITIONER/PROVIDER APPEAL PROCESS

Dispute

A practitioner/provider may submit a dispute by calling one of the numbers listed below or by writing to the P.O. box listed on the Explanation of Benefits (EOB) statement and/or denial letter related to the issue being disputed. Practitioners/providers have 180 days from receiving the

initial decision to submit a dispute (unless [state regulations](#) or your provider contract allow more time).

To facilitate the handling of an issue, practitioners/providers should state the reason(s) they disagree with our decision. Additionally, callers should have the denial letter or EOB statement and the original claim available for reference.

- 1-888-632-3862 for indemnity and PPO-based benefits plans
- 1-800-624-0756 for HMO-based benefits plans

Claims payment disputes are subject to our reconsideration process, while utilization review disputes are handled as Level 1 Appeals.

Reconsideration

If a practitioner/provider would like to dispute a claim payment decision, he or she must contact us to have the decision reconsidered. This is the first step in disputing a claim payment decision. A Provider Service Center (PSC) representative will research the handling of the claim in question. We will generally resolve claims payment issues related to contract application within three to five business days. If the decision is in the practitioner's/provider's favor, we will recalculate and reprocess the claim for any services affected by the decision.

It may be necessary to forward claims payment issues involving clinical or coding reviews to a specialty unit for investigation and resolution. We will issue a response within 30 business days if no additional information is required, or within 30 business days of when the specialty unit receives any additional requested information. If the decision is in the practitioner's/provider's favor, we will recalculate and reprocess the claim for any services affected by the decision.

Following reconsideration, if the decision is not in the practitioner's/provider's favor, he or she may initiate a Level 1 Appeal. We will provide instructions on how and when to file an appeal when we issue the reconsideration decision.

Level 1 Appeal

If a practitioner/provider is not satisfied with the reconsideration decision (for claims disputes) or an initial utilization review decision, he or she may request a Level 1 Appeal, either verbally or in writing.

We will notify practitioners/providers of our Level 1 decision in writing within 30 business days of our receipt of the appeal, unless we need additional information. If we need additional information, we will send the Level 1 Appeal decision within 30 business days of the receipt of the additional requested information.

If the Level 1 Appeal decision is in the practitioner's/provider's favor, we will recalculate and reprocess the claim for any services affected by the decision. If the Level 1 Appeal decision upholds our original position, we will send a written response. For practitioners, the notice will include information about their right to request a review of the adverse determination as a Level 2 Appeal. For providers, the notice will include our final determination.

Level 2 Appeal

If practitioners are not satisfied with the Level 1 Appeal decision, they may request a Level 2 Appeal either verbally or in writing within 60 calendar days from the date of the Level 1 Appeal decision. Providers are not eligible for a Level 2 Appeal, except as required by state regulations.

A reviewer not associated with the Level 1 Appeal review will examine the Level 2 Appeal. We will notify practitioners of our Level 2 Appeal decision in writing within 30 business days of our receipt of the appeal, unless we need additional information. If we need additional information, we will send the Level 2 Appeal decision within 30 business days of receipt of the additional requested information.

If the Level 2 Appeal decision is in the practitioner's favor, we will recalculate and reprocess the claim for any services affected by the decision. If the Level 2 Appeal decision upholds our original position, we will send a final resolution letter.

POST-APPEAL REVIEW PROCESS

If providers/practitioners have exhausted our appeal processes, there may be an opportunity for additional review by an external organization. There is no fee for using our appeal process; however, there may be a charge if an independent external review process is pursued.

Billing Dispute Resolution

In addition to complying with specific state regulations regarding external or independent review processes, we offer a Billing Dispute Resolution Process to practitioners who were class members of the physician class action settlement with Aetna. According to the Billing Dispute Resolution Process, an external organization reviews how we apply coding and payment rules and methodologies to patient-specific factual situations, including the appropriate payment when two or more CPT codes are billed together, or if a payment-enhancing modifier is appropriate.

More information about this process is available at:
www.aetna.com/provider/billing_dispute_process.html

Medical Necessity External Review

Members of the physician settlement agreement with Aetna can also obtain an independent review of disputed medical necessity issues when a plan member has access under our External Review Policy or applicable law.

Under this process, an Aetna-contracted independent review organization (IRO) will perform an external third-party binding review of eligible medical necessity and experimental or investigational coverage denials. State mandates related to external review will take precedence. We will process practitioner appeals related to pre-service, concurrent or urgent medical necessity review decisions as member appeals, and they may be subject to the member External Review Process.

Eligible practitioners may request external review when all of the following criteria are met:

- Internal appeals are exhausted.
- The coverage denial involves more than \$500.
- The coverage denial is based on lack of medical necessity or it is determined that the service at issue is experimental or investigational.
- The member has not previously or concurrently requested an external review of the coverage denial.

More information about this process is available at:
www.aetna.com/provider/physician_external_review.html

More information about our member medical necessity External Review Process is available at:
www.aetna.com/products/ext_review.html

STATE LAWS AND REGULATIONS

To the extent that this procedure varies from the applicable laws and/or regulations of an individual state, the requirements of the state regulation are adopted and supersede Aetna's policy. Aetna's Law department makes the first determination when there is any question as to the applicability of a law.

QUESTIONS

If you have any questions about our practitioner/provider appeal process, please contact our Provider Service Center:

- 1-888-632-3862 for indemnity and PPO-based benefits plans
- 1-800-624-0756 for HMO-based benefits plans