



Practitioner/provider dispute process

This document gives practitioners and providers instructions for disputing 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 dispute 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 services. Examples include physicians, podiatrists and independent nurse practitioners.

Providers are institutional providers and suppliers of health care services. Examples include hospitals, skilled nursing facilities, independent durable medical equipment vendors 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 reimbursement or coding decision, or a claim that requires reprocessing.

Level 1 appeal is an oral or written request by a practitioner/provider to change:

- an adverse reconsideration decision
- an adverse initial claim decision based on medical necessity or experimental/investigational coverage criteria
- an 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 predetermination of services not requiring precertification.

Utilization review issues relate to decisions made during the precertification, concurrent or retrospective review processes for services that require 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.

About the process

Dispute

A practitioner/provider may submit a dispute by calling our Provider Service Center at:

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

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 allows more time).

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

Claims payment disputes related to reimbursement or coding are subject to our reconsideration process, while initial adverse claims decisions based on medical necessity or experimental or investigational coverage criteria, as well as utilization review disputes, are handled as Level 1 appeals and are reviewed by clinicians.

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 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 reimbursement 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

A practitioner/provider may request a Level 1 appeal, either verbally or in writing, if he or she is not satisfied with:

- the reconsideration decision (for claims disputes)
- an initial claim decisions based on medical necessity or experimental/investigational coverage criteria
- an initial utilization review decision

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 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 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.

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 to external review under our external review policy or applicable law. The final resolution letter indicates if a provider has access to external review.

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.

You can find more information about our member medical necessity external review process at: www.aetna.com/products/ext_review.html

State laws and regulations

To the extent that our policy varies from the applicable laws and/or regulations of an individual state, the requirements of the state regulation are adopted and supersede our policy, except with respect to appeals relating to Aetna Medicare plans. (State laws do not apply to Medicare plans.) Aetna's law department makes the final determination when there is any question as to the applicability of a law.

Questions

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

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