



## Practitioner/provider dispute process questions and answers

### Who can use Aetna's practitioner/provider dispute process?

Any practitioner or provider who provides health care services to Aetna members can use the dispute process. For the purposes of our dispute process:

- **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.

### What is a dispute?

A dispute is a disagreement regarding a claim or utilization review decision.

### What is the procedure for disputing a claim decision?

You may contact us by phone or mail within 180 days of receiving the decision (unless [state regulations](#) or your provider contract allow more time). To facilitate the handling of an issue, you should state the reason(s) you disagree with our decision, and you should have the denial letter or Explanation of Benefits (EOB) statement and the original claim available for reference.

### What number should I call to dispute a claim decision?

Call our Provider Service Center:

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

### Where should I send a claim dispute if I am submitting by mail?

See the [quick reference guide](#) or the denial letter/Explanation of Benefits (EOB) statement in question for the address.

### What is a reconsideration?

A reconsideration is a formal review of a previous claim reimbursement or coding decision, or a claim that requires reprocessing.

### Can I just resubmit a claim if I do not agree with the initial claim payment decision?

No. You must indicate verbally or in writing the reason for your claim dispute. If you resubmit the claim with no additional information, we will deny the claim as a duplicate of the original claim.

### What is a Level 1 appeal?

A Level 1 appeal is a verbal 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

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.

**What is a Level 2 appeal?**

A Level 2 appeal is a verbal or written request by a practitioner to change a Level 1 appeal decision.

**How long do I have to submit a dispute?**

See the [quick reference guide](#) for the timeframes to submit a reconsideration, Level 1 appeal or Level 2 appeal.

**What is Aetna's timeframe for responding to a dispute?**

See the [quick reference guide](#) for our timeframes for responding to reconsideration, Level 1 appeal or Level 2 appeal.

**Can all practitioners and providers file both Level 1 and Level 2 appeals?**

No. According to our policies, providers (hospitals and facilities) may only file Level 1 appeals; however, in certain states they may have a second level of appeal. Practitioners may file both Level 1 and Level 2 appeals.

**What can I do if I am contesting an urgent matter?**

You may request an expedited appeal. Expedited appeals are available when precertification of urgent or ongoing services has been denied and a delay in decision making might seriously jeopardize the life or health of the member or otherwise jeopardize the member's ability to regain maximum function.

We will resolve expedited appeals within 36 hours of receipt. Please note that the member appeals process applies to expedited appeals. Post-service appeals are not eligible for expedited handling. Refer to [the member health plan benefits FAQs](#) for more details.

**What can I do if I disagree with Aetna's decision after exhausting all levels of appeal?**

Practitioners who were members of the physician class action settlement may seek independent external review for certain types of issues. See this link for more information:

[www.aetna.com/provider/physician\\_external\\_review.html](http://www.aetna.com/provider/physician_external_review.html)

**Is there a fee for using Aetna's dispute process?**

No. However, there may be a charge if you decide to pursue an independent external review process.

**What if my state has regulations that differ from Aetna's process?**

With the exception of appeals relating to Aetna Medicare plans, we follow all state laws and regulations. (State laws do not apply to Medicare plans.) State mandates requiring different time periods will take precedence, except as previously noted.

**What is a member’s “authorized representative”?**

A member may designate a practitioner/provider as an “authorized representative” to file an appeal on his or her behalf for claims involving pre-service, urgent care or inpatient urgent concurrent review if the practitioner/provider is the member’s primary physician or a health care professional with knowledge of the member’s medical condition. The member appeal process applies to pre-service appeals.