

Aetna's practitioner/provider dispute resolution policy for California HMO business

For provider disputes pertaining to claim issues, the requirements in this policy apply to claims (and disputes related to those claims) for services rendered on or after January 1, 2004.

Dispute resolution policy for practitioners, facilities and provider organizations

Provider disputes can include claims and other billing issues, contract issues and requests for reimbursement of claims overpayment. We want to process and resolve provider disputes quickly, fairly and cost-effectively. Our policy is the same for both in-network and out-of-network providers and does not include arbitration.

We don't discriminate or retaliate against providers who file a dispute. Filing a dispute is free. However, providers are responsible for any costs they may realize as a result of using our dispute resolution process. These costs may include postage for mailing us information to help us resolve the dispute.

Our Provider Resolution Team is in charge of our dispute resolution process. They keep copies of all the information related to a provider dispute for at least five years. This information includes the provider dispute and all related notes, documents and other information that we used to reach our final decision.

Providers who are not satisfied with our final determination may have access to additional levels of review. Please see our national practitioner/provider dispute process.

Required information for submitting disputes

California regulations require that every provider dispute include the following information:

- Provider's name.
- Provider's tax identification number.
- Provider's contact information.

Along with the above information, some disputes require additional information.

Disputes about a claim or a request for reimbursement of a claim overpayment must also include:

- An explanation of the issue, including the original claim number.
- The date of service.
- An explanation of why the provider believes the payment amount, request for additional information, request for reimbursement of a claim overpayment, or other action we took is incorrect.

Provider disputes that are not about a claim, for example a contract dispute, must also include:

- An explanation of the issue.
- The provider's position on that issue.

Disputes involving a member or group of members must also include:

- The name(s) and identification number(s) of each member.
- An explanation of the issue, including the date of service.
- The provider's position on the dispute.

Disputes involving multiple claims:

Providers may batch multiple claims, billing or contractual disputes that are similar and file them as a single dispute. We recommend that disputes filed in batches be submitted in the following format:

- Sort disputes by similar issue.
- Provide a cover sheet for each batch of similar issues. Individually number and list the required information for the type of dispute (refer to the above sections) for each disputed item within the batch.
- Number each cover sheet.
- Provide a cover letter for the entire submission. The cover letter should describe each provider dispute and reference the applicable numbered cover sheets.

Provider disputes involving a delegated payer determination must also include:

- An explanation of the issue, including a copy of the original claim.
- The date of service.
- An explanation of why the provider believes the payment amount, request for additional information, request for reimbursement of a claim overpayment, or other action we took is incorrect.
- A copy of the delegated payer's written determination/correspondence.

Provider disputes that do not include all required information may be returned to the submitter.

Provider disputes submitted on behalf of a member or a group of members treated by the provider will be handled according to the Aetna member grievance process, not the provider dispute resolution process. Member issues may include a clinical appeal of a utilization management decision, a clinical dispute during the concurrent care review process or a provider seeking an expedited review on behalf of a member.

Submission of provider disputes

Providers can submit written disputes to:

Aetna Correspondence Unit

P.O. Box 24019

Fresno, CA 93779-4019

Written disputes can be submitted on the Provider Dispute Resolution Request Form (Attachment A) or in the form of a letter.

Providers can call our Provider Service Center at 1-800-624-0756 with questions about the dispute process.

Verbal complaints from providers will be handled through our national practitioner/provider dispute process.

PROVIDER DISPUTE PROCESS TIMEFRAMES

DESCRIPTION		TURNAROUND TIMEFRAME
DEADLINE FOR PLAN RECEIPT OF PROVIDER DISPUTES	Dispute related to an individual claim, billing dispute, or contractual dispute;	Deadline: 365 days after the most recent action, or in the case of inaction, 365 days after time for contesting or denying claims has expired.
	OR Dispute related to a demonstrable and unfair payment pattern by the Plan	
	Dispute regarding a Plan notice of overpayment	Deadline: Within 30 working days of receipt of the Plan notice of overpayment of a claim
	Amended Provider Dispute	Deadline: Within 30 working days of the date of provider's receipt of a returned dispute with written Plan notice
TIME PERIOD FOR ACKNOWLEDGEMENT	Electronic Provider Dispute (directly into the system)	Provided within 2 working days of the date of receipt of the electronic provider dispute
	Paper Provider Dispute (mail, fax, e-mail, physical delivery)	Provided within 15 working days of the date of receipt of the paper provider dispute
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Plan's goal is to resolve and issue written determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
PAST DUE PAYMENTS AND INTEREST AND PENALTIES	Resolution of a dispute involving a claim, which is determined in whole or in part in favor of the provider, shall include the payment of any outstanding monies determined to be due and all interest due.	Plan goal is to issue payment with the resolution letter and in all cases payment will be made no later than within 5 working days of the issuance of the written determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.



PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Aetna Correspondence Unit
P.O. Box 24019
Fresno, CA 93779-4019

*PROVIDER NPI:

*PROVIDER TAX ID:

PROVIDER NAME:

PROVIDER ADDRESS:

PROVIDER TYPE MD Mental Health Professional Mental Health Institutional Hospital ASC
 SNF DME Rehab Home Health Ambulance Other _____

(please specify type of "other")

* CLAIM INFORMATION Single Multiple "LIKE" Claims (complete attached spreadsheet) Number of claims: _____

* Patient Name:

Date of Birth:

* Health Plan ID Number:

Patient Account Number:

Original Claim ID Number: (If multiple claims, use attached spreadsheet)

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)

Original Claim Amount Billed:

Original Claim Amount Paid:

DISPUTE TYPE

- Claim Seeking Resolution Of A Billing Determination
- Appeal of Medical Necessity / Utilization Management Decision Contract Dispute
- Disputing Request For Reimbursement Of Overpayment Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print)

Title

()
Phone Number

Signature

Date

()
Fax Number

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

For Health Plan/RBO Use Only

Tracking Number: _____ Provider ID #: _____
Contracted _____ Non-Contracted _____

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" (claims denied for the same reason)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page _____ of _____

CHECK HERE IF ADDITIONAL
 INFORMATION IS ATTACHED
 (Please do not staple)