Aetna Better Health Webinar Series

Provider Experience
Network Relations Team

LaShawn Bailey
Kim Heggenstaller
Bridget Paris

May 2021

Housekeeping

- All lines will be muted to reduce background noise
- Use the Q & A to submit any questions to ALL PANELISTS
- The presentation will be available on our website under Past Provider Education Webinars within a week and here is the link: https://www.aetnabetterhealth.com/pennsylvania/providers/education

As a team, we are committed to supporting our providers and working together toward positive outcomes for your patient, our member.

— YOUR PROVIDER EXPERIENCE TEAM —

La Shawn Bailey

Michelle Bogard

Kim Heggenstaller

Bridget Paris

The Aetna Better Health of PA Webinar Collaboration Team

We welcome you and appreciate you for taking the time to join us today!

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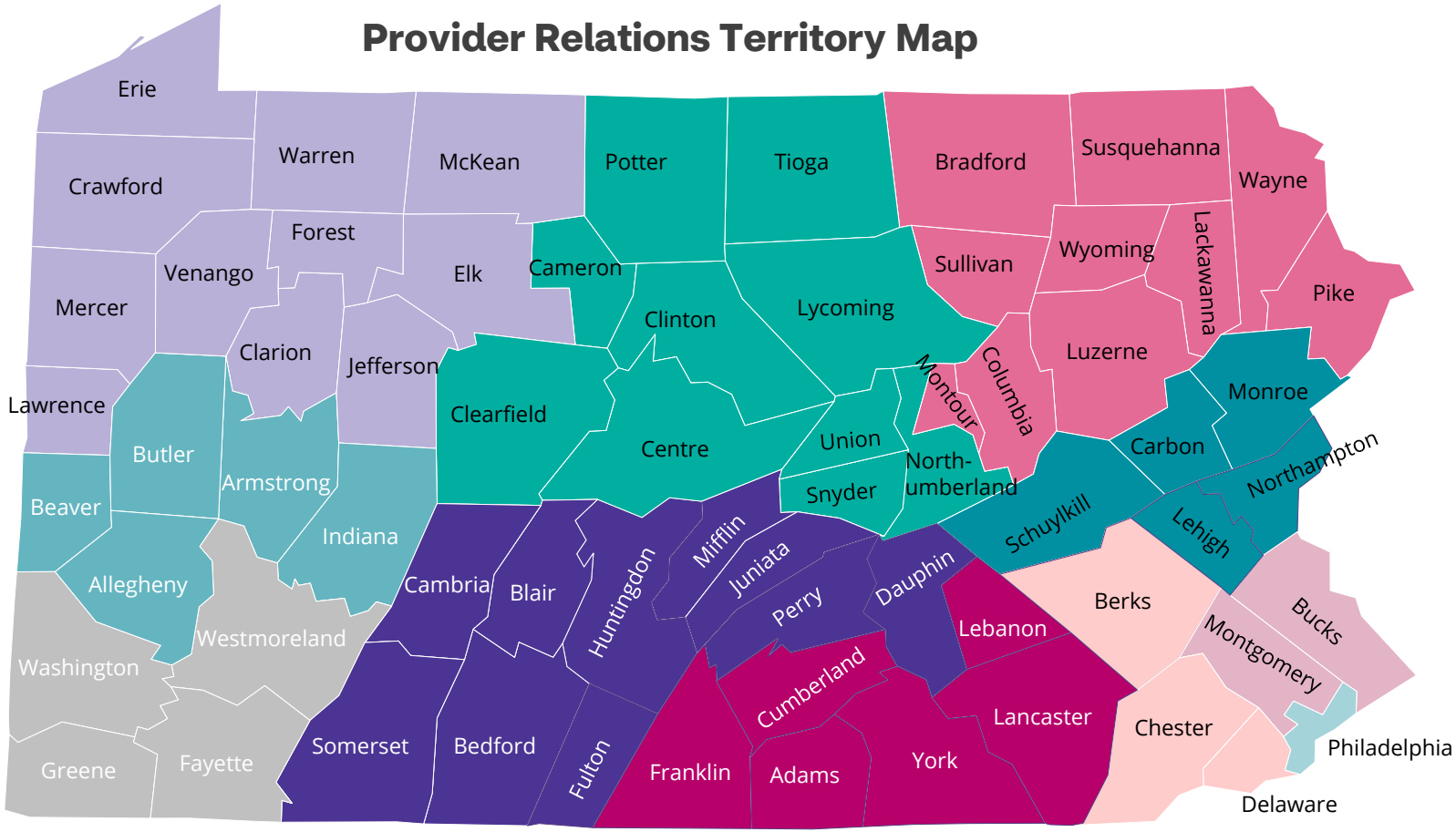
May 26, 2021

Network Relations Consultants Territory Map & List

Provider Relations Territory Map



Sherry Flannery	Melinda Roach	Kim Heggenstaller	Anna DiPietro
Vacant	Jacelyn Cressman	Kimberly Young	Kari Heggs
Vacant	Michelle Bogard	Michael Quinn	Teresa Washington (All FQHC's)

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Large Group & Hospital Assignments

Provider Group	Representative
Advocare Pediatrics	Kari Heggs
Allegheny Health Network	Vacant
Children's Hospital of Phila.	La Shawn Bailey
Coordinated Health	Vacant
Crozer Keystone	Kimberly Young
CVS MinuteClinic	Kari Heggs
Detweiler Family Medicine	Kimberly Young
Drexel Medicine	LaShawn Bailey
Einstein Health Network	Anna DiPietro
FQHC's	Teresa Washington
Geisinger	Kim Heggenstaller
Jefferson Health	Anna DiPietro
Lehigh Valley Health Network	Jaclyn Cressman

Provider Group	Representative
Trinity (Mercy) Health	Kari Heggs
Nemours	Kimberly Young
Penn State/Hershey Health	Kimberly Young
Phoenix Rehabilitation & Health Services, Inc.	Vacant
Quest Diagnostics	Kari Heggs
St. Christopher's	Kimberly Young
St. Mary Medical Center	Kari Heggs
Tower Health	Kimberly Young
UPMC Cole	Melinda Roach
UPMC Pinnacle	Michelle Bogard
UPMC Susquehanna	Melinda Roach
UPMC – Western PA	Melinda Roach
WellSpan Health	Michael Quinn

About Michael:

Michael has over 20 years experience in the healthcare industry. His professional career includes contracting, marketing, provider relations and recruiting.

His territory assignment includes Adams, Cumberland, Franklin, Lancaster, Lebanon and York counties.

He currently resides in Chester county and loves to spend time with his family and friends. In his spare time, Michael loves driving around in his convertible.

Michael Quinn

Email: QuinnM2@aetna.com

Phone: (610) 412-6307

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Agenda

Provider Appeals and Disputes

- What is an Appeal?
- Steps to follow when submitting an appeal
- Appeal Trends and Reminders
- What is a Dispute?
- Appeal and Dispute Resolution
- Timeframes and Helpful Reminders
- Contact Information

Presenter: Bridget Paris

Provider Appeals & Disputes

What is an Appeal?

An appeal is a formal post service expression of dissatisfaction in which a provider requests that ABH change an adverse determination for care or services rendered to a member.

When submitting an appeal, be sure to:

1. Use the Appeal Form to submit your appeal in writing to the appeals department

2. State the factual basis for the relief requested.

3. Include all supporting documentation wit the appeal, such as claim, medical records, office notes, operative notes, remittance advice and any other substantial documentation.

IMPORTANT: Failure to specifically state the factual basis of the appeal and/or failure to submit supporting documentation may result in denial of the provider appeal. The Provider Clinical Appeals committee reviews all appeals and makes the final determination.

Appeal Submission Trends and Reminders

- Medical Records are being submitted to the appeals department without a letter or appeal form
- A mailing address to return the appeal determination is not supplied in the appeal letter or on the appeal form
- Requests from providers for 2nd Level provider Appeals even though the 1st Level Appeal Decision is final
- When appealing denied Prior Authorizations on behalf of the member, member consent is required:
  - Requests without written member consent are pended for 30 days and a *Consent for Provider to File a Grievance for Member Form* is sent to the member
  - The Appeal Review **cannot be started** until written member consent is received
    - If consent is received, the case will be started for review which could take up to 30 days
    - If consent is not received, the case is closed as ineligible for review

What is a Dispute?

A dispute is a verbal or written expression of dissatisfaction concerning a decision that directly impacts the provider. Disputes are typically administrative and do not include decisions concerning medical necessity. Formal provider disputes must be received in writing.

Disputes can be resolved through multiple avenues such as:

- ABH Secure Web Portal
- Availity Portal
- Claim Inquiry and Claims Research (CICR)
- Network Relations Consultant (assigned provider rep)

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Appeal Timeframes

Appeal Filing
Appeals must be received within (60) days of claim notification.

Acknowledgement
ABH will send acknowledgement within (5) business days of receipt.

Appeal Decision
A decision will be rendered within (60) calendar days after receipt.

Appeal Extensions
ABH may request an extension of up to (30) calendar days, if necessary.

Decision Letters
ABH sends letters within (5) business days after a committee decision is made.

*Timeframes may vary depending on terms of the provider contract.

Appeal Reminders

Submit post appeal claim review appeals to Cotiviti and/or Equian address when applicable If the appeal is upheld, the provider can then file a formal appeal to the plan.

Ensure that provider addresses are legible and accurate on the appeal letter so that responses can be sent to the correct address.

Ensure that the contract in place for the date of service in question aligns with the appeal request.

Utilize the P2P process for pre-service denials. If the P2P timeframe is missed, a new prior authorization request form with the additional information required can be sent.

ABH is required to follow up with providers on claim denials notices submitted to the plan as member complaints.

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Miscellaneous Contact Information

Claims & Corrected Claims Mailing Address

Aetna Better Health of PA
PO Box 62198
Phoenix, AZ 85082-2198

Equian

Equian Claims Resolution
600 12th Street, Suite 300
Golden, CO 80401

Claims Inquiry Claims Research (CICR) for Claim Inquiries

Provider Services Phone Unit
866-638-1232

Prior Authorization Department

Phone 866-638-1232
Fax 877-363-8120

*Prior to providing services, go to the PA Requirement Search Tool under Health Tools on the ABHPA Provider Portal

Prior Auth Checklist

Cotiviti Clinical DRG Reviews

Aetna Better Health Cotiviti
Clinical Chart Validation
Hillcrest II Building
731 Arbor Way, Suite 150
Blue Bell, PA 19422

Fax (less than 75 pages)
203-529-2778

Appeals Contact Information

Aetna Better Health

ATTN: Appeals Department

1425 Union Meeting Road

Blue Bell, PA 19422

Fax

860-754-1757

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Thank you for joining us today! We look forward to hosting you on June 30th 2021