March 4, 2020

Reminder of Upheld Dispute Response

Please see below for sample of initial notice of action response letter:

Dear Provider,

On the original denial, the clinical determination is sent on the Notice of Action (NOA) Letter at the time of the initial request for the prior authorization. Please see example of the NOA clinical determination below:

Date: [redacted] **Member number:** [redacted]

Name: [redacted]

Your request was denied
We've denied the medical services/items listed below requested by you or your provider:
Inpatient Medical Admission Stay

Why did we deny your request?
We denied the medical services/items listed above because:

Your hospital asked us to pay for your inpatient stay for asthma. (a lung condition causing difficulty with breathing)

We cannot approve inpatient because we do not see that you have/had:
• Airflow less than 60% of your normal.
• Treatment and did not get better within 24-48 hours.
• Problems with pressure or heartbeat.
• Other problems that got worse because of your asthma.

Based on the records we have; this might be an observation stay. You will not have to pay for this. If you have any
(MCG ORG M-60 Asthma and CMS Medicare Benefit Policy Manual
Chapter 1- Inpatient Hospital Services).

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor to inform him/her of this decision. Your doctor can call Aetna Better Health Premier Plan about this decision.

You have the right to appeal our decision
You have the right to ask Aetna Better Health Premier Plan to review our decision by asking us for an appeal. Ask Aetna Better Health Premier Plan for an appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Aetna Better Health Premier Plan" for information on how to ask for a plan level appeal.

Please see below sample of how the second level dispute response will reflect on the provider remit:

The following CARC/RARC Codes below are used on the claim and displayed on the remit when disputes submitted via mail or uploaded into the Provider Portal are sent for Medical Director Review, and when the claim has been reviewed and returned from medical review and the determination is "original decision stands."

Original Claim	Received	Action	Decision	CARC / RARC	CARC Description	RARC Description
Original claim denied for no authorization or authorization is in DENIED status	Medical records are received with resubmission of claim	Submit for Review	MD maintains original decision	50 / N661	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.	Documentation does not support that the services rendered were medically necessary.
Appeal / dispute received	Claims are received from G/A team; call tracking or email. These are not C70 claims	Submit for Review	Original decision stands	50 / N661	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.	Documentation does not support that the services rendered were medically necessary.
Original claim denied per ClaimCheck edits	Medical records are received with resubmission of claim	Submit for Review	Original decision stands	193 / MA46	ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY	ALERT: THIS CLAIM/SERVICE WAS CHOSEN FOR COMPLEX REVIEW

See Remit Example Below:

Patient: [redacted]
Member ID:
Date of Birth:
Final DRG:
Place of Service: 111

Patient Acct #: [redacted]
Authorization ID:
Provider:
Severity of Illness:

Claim Status: [redacted]
Claim#:
Refund Amount:
Received Date:

#	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Unit	Billed Amount	Disallowed	Allowable Amount	Patient Responsibility			COB Paid	Processed Amount	Discount/ Interest	Net Amount
										Co-Pay	Ded.	Co-Ins				
1	11/01/19			0110	FFS	3	5,400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	11/01/19			0250	FFS	228	3,520.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	11/01/19			0258	FFS	22	568.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	11/01/19			0260	FFS	1	900.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	11/01/19			0271	FFS	11	385.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6	11/01/19			0300	FFS	1	1,515.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7	11/01/19			0320	FFS	1	280.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8	11/01/19			0762	FFS	14	1,590.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
					Claim Totals		14,158.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Code/Description

Adjustment of Claim [redacted]
MA07 - ALERT: THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID FOR REVIEW.
MA67 - ALERT: CORRECTION TO A PRIOR CLAIM
193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
MA46 - ALERT: THE NEW INFORMATION WAS CONSIDERED BUT ADDITIONAL PAYMENT WILL NOT BE ISSUED
N661 - DOCUMENTATION DOES NOT SUPPORT THAT THE SERVICES RENDERED WERE MEDICALLY NECESSARY.