RECONSIDERATION/APPEAL/RESUBMISSION AT-A-GLANCE

Aetna Better Health® of Kansas

DESCRIPTION

RECONSIDERATION – Processed by the Recon/Appeals Team

The purpose of a Claim Reconsideration Request is to dispute/request review of the processing of a clean claim. A clean claim must be on file prior to submitting a reconsideration request.

The claim reconsideration process is an optional first level, prior to submitting a formal written appeal.

Claim reconsiderations must be submitted per individual member. Do not submit bulk reconsiderations (i.e., one appeal for multiple members).

Providers may submit one reconsideration. If a provider receives an adverse decision to the reconsideration, they may file an appeal.

APPEAL – Processed by the Recon/Appeals Team

The purpose of an Appeal is to 1) dispute/request review of the processing of a clean claim, which requires a clean claim to be on file, or 2) post service denial of prior authorization.

Appeals may be filed if the provider wishes to bypass the reconsideration process.

Appeals must be in writing.

Appeals must be submitted per individual member. Do not submit bulk appeals (i.e., one appeal for multiple members).

Providers may submit one appeal. If a provider receives an adverse decision to the appeal, they may file a written request for State Fair Hearing or EITPR (External Independent Third Party Review).

RESUBMISSION – Processed by the Claims Team

The purpose of a Resubmission is to get a clean claim on file.

A claim that requires correction, retro-eligibility, etc. all require review of additional information; therefore, these are considered non-clean and must be "resubmitted" in order to make the claim clean.

A resubmitted claim is not the same thing as a reconsideration or appeal of a claim (i.e., it does not qualify as a claim dispute).

There is no limit on the number of times a provider may file a resubmission, in order to get a clean claim on file.

EXAMPLES

Reconsideration

- Claim Denial Disputes, such as:
  - Timely filing
  - Missing Prior authorization (i.e., review medical necessity)
  - Code Editing (i.e., modifiers)
  - Non-Covered Services
- Payment Disputes
- Retro Fee Schedule / Rate updates (note: Aetna can only pay up to the billed charge amount so in some cases, a resubmission will be needed)

Appeal

- Claim Denial Disputes, such as:
  - Timely filing Missing Prior authorization (i.e., review medical necessity)
  - Code Editing (i.e., modifiers)
  - Non-Covered Services
- Payment Disputes
- Retro Fee Schedule / Rate updates (note: Aetna can only pay up to the billed charge amount so in some cases, a resubmission will be needed)
- Post service denial of Prior Authorization
- Adverse decision of a Reconsideration Request

Resubmission

- Claim denied for missing documentation that is needed in order for the claim to be classified as "clean," such as:
  - COB
  - Invoice
  - Itemized Bill
  - Needing Medical Records
- Provider needs to submit a Corrected Claim (i.e., change coding, update charge amount in order to get retro rate, etc.).
- Member receives Retroactive Eligibility
- Provider receives Retroactive Participation or State Eligibility

HOW TO FILE

Reconsideration

Orally:
Call the Provider Experience department at 855-221-5656 or for the Hearing Impaired, Relay711.

Paper Submission:
Aetna Better Health of Kansas
Attn: Reconsideration
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Email or Fax
email: KS AppealsandGrievances@AETNA.com
Fax: 1-833-857-7050

Electronically via Availity
Please refer to www.aetnabetterhealth.com to register for training and Provider Portal instruction.

Appeal

Paper Submission:
Aetna Better Health of Kansas
Attn: Appeals
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Email or Fax
email: KS AppealsandGrievances@AETNA.com
Fax: 1-833-857-7050

Electronically via Availity
Must include in writing that the submission is an appeal, or it will be processed as a reconsideration.

Please refer to www.aetnabetterhealth.com to register for training and Provider Portal instruction.

Resubmission

Electronically via EDI 837
If no additional documentation is needed, may submit an 837. Must submit a frequency code of seven (7) Replacement/Corrected Claim or eight (8) Voided/Cancelled Claim to prevent the claim from denying as a duplicate.

Electronically via Availity or ABHKS Web Portal
These options are available for attaching documentation. Please refer to www.aetnabetterhealth.com to register for training & Provider Portal instruction.

Paper Submission
Please include the following:
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy) is acceptable.
- A copy of the remittance advice
- Any additional documentation required.
- A brief note describing requested correction.

Label as "Resubmission" at the top of the claim in black ink and mail to:
Aetna Better Health of Kansas
P.O. Box 982961
El Paso, TX 79998-2961

FILING TIMEFRAME

Reconsideration

Within 120 calendar days from the date of the notice of the claim denial. Note: an additional three (3) calendar days is allowed for mailing time.

Appeal

If a reconsideration was not requested:
Within 60 calendar days of the date of the notice of adverse action. Note: An additional three (3) calendar days is allowed for mailing time.

If a reconsideration was requested:
Within 60 calendar days from the date of the reconsideration resolution letter. Note: An additional three (3) calendar days for mailing time.

Resubmission

365 days from the date of service to resubmit a revised version of a processed claim

As defined by KanCare, a clean claim is defined as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system.