AETNA

Aetna has a Quick Reference webpage related to the Dispute and Appeal process.

Reconsideration
If an organizational provider/practitioner’s issue is eligible for Reconsideration, it will take place prior to the appeal process. Eligible issues for Reconsideration include, but are not limited to: provider contract issues, claim payment policies and processing errors.

- Must be filed within 180 calendar days of the initial claim decision
- Request may be submitted online through Navinet
- Alternatively, Aetna may be contacted by phone at 1-800-624-0756 for HMO-based benefits plans and WA Primary Choice plans, or 1-888-632-3862 for indemnity and PPO-based benefit plans.

Aetna will issue a response within 3-5 business days if no additional information is required, or within 30 business days if further review is required, along with additional requested information. If the decision is in the physician’s favor, Aetna will recalculate and reprocess the claim for any services affected by the decision.

Level 1 Appeal
If following Reconsideration and the decision is not in the physician’s favor, a Level 1 appeal may be requested verbally or in writing.

- Must be requested within 60 calendar days of the Reconsideration decision (for claims disputes).
- May be requested on an initial claim decision based on medical necessity or experimental/investigational coverage criteria.
- May be requested based on an initial precertification/patient management review decision.

Aetna will issue a response within 30 business days if no additional information is required, or within 30 business days following receipt of additionally requested information.

Level 2 Appeal
A Level 2 appeal is available to practitioners if the Level 1 appeal decision is unsatisfactory. The Level 2 appeal is not available to organizational providers, except as required by state regulations. Organizational providers, include but are not limited to: hospitals, freestanding surgical centers, diabetic treatment centers and sleep diagnostic centers.

- Must be requested within 60 calendar days from the date of the Level 1 appeal decision. Aetna will issue a response within 30 business days if no additional information is required, or within 30 business days following receipt of additionally requested information.

**BCBSTX**

BlueCross BlueShield of Texas (BCBSTX) has two levels of appeals. All require the use of the Claim Review Form.

**Claim Dispute Process**

**Level 1**
- Physician and/or staff must complete the Claim Review Form.
- Form must be completed and submitted within 180 days of receiving the Texas Explanation of Payment (EOP), or the date of the BCBSTX Provider Claims Summary (PCS), for the claim in dispute.
- BCBSTX will complete the first claim review upon submission and respond with a written notification within 45 days.

**Level 2**
- If BCBSTX returns an unfavorable appeal, then the physician and/or staff must appeal within 15 days from the date of when the determination was received.
- BCBSTX will complete the second claim review within 30 days following the receipt of the request and provide written notification of the determination.

**Over-payment Dispute Process**

**Level 1**
- First appeal must be submitted with a completed Claim Review Form within 30 days following the receipt of written notice of request for refund due to an audited payment.
- Must be submitted within 45 days following the receipt of written notice of request for refund due to over-payment.
- Physician and/or staff must complete the Claim Review Form.
- BCBSTX will complete first claim review and respond with a written notification within 45 days after submittal of form.

**Level 2**
- If BCBSTX returns an unfavorable appeal, then physician and/or staff must appeal within 15 days from the date the determination was received.
- BCBSTX will complete the second claim review within 30 days following the request and will provide written notification of the determination.

**Audited Payment**

**Level 1**
- Physician and/or staff must complete a Claim Review Form.
- Once form is submitted, BCBSTX will complete the first claim review within 45 days and will provide written notification of determination.
Level 2

- If BCBSTX returns an unfavorable appeal, then the physician and/or staff must appeal within 15 days following the first claim review determination.
- BCBSTX will complete the second claim review within 30 days following the second request and will provide written notification of the determination.

CIGNA

Cigna strives to informally resolve issues raised by providers at the time of initial contact. If the issue cannot be resolved informally, Cigna HealthCare offers an internal appeal process for resolving disputes with providers. Please visit CIGNA Appeal Policy and Procedures for Providers for instructions.

Provider Reconsideration Request

Step 1

- Contact Cigna’s Customer Service Department (number located on the back of the member's ID card) to discuss the issue.
- You will be advised of your right to appeal if the representative is unable to assist.

Step 2

- Complete and mail the Request for Health Care Professional Payment Review form and/or appeal letter along with all supporting documentation to the address identified in Step 3 on the form.

Provider Payment Review

Level 1

The First Level must be initiated within 180 calendar days from the date of the initial payment or denial decision from CIGNA HealthCare. Appeal requests will be handled by a reviewer who was not involved in the initial decision.

- To be eligible for this program, providers must first exhaust the internal appeal process and must request the review within 180 days of the date of the Second-Level denial letter or First-Level denial letter if the First-Level review was conducted by a provider in the same specialty. The provider should go to the CIGNA Appeal Policy and Procedures for Providers webpage and download the Request for the Health Care Professional Payment Review-HCP form. Contact the Cigna HealthCare Customer Service Department at the toll-free number listed on the back of the Cigna HealthCare participant's ID card to review any claim denials or payment decisions.
- If the Customer Service Representative is unable to determine that an error was made with the claim adjudication decision and correct it, the provider may appeal the decision.
- Provider should go to the CIGNA Appeal Policy and Procedure for Providers webpage and download the Request for Provider Payment Review - TX form.
- Include a copy of the original claim, the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable, and any supporting documentation to support the appeal request
- For appeals with a clinical component, such as services denied for no prior authorization, submit supporting documentation, including a narrative describing the subject of the appeal, an operative report and medical records as applicable
- Mail your appeal, payment review form and supporting documentation to: CIGNA Appeals Unit, P.O. Box 188011, Chattanooga, TN 37422
The Second Level must be initiated within 60 calendar days of the date on the First-Level review decision letter.

- Include a copy of the original claim, the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable, and any additional documentation to support the appeal request.
- For appeals with a clinical component, such as denials for failure to obtain prior authorization, provide supporting documentation including a narrative describing the subject of the appeal and any additional clinical documentation (e.g., operative report and medical records) that was not previously submitted. It is NOT necessary to resubmit the same documentation that was included in the First Level Review request.
- Mail your appeal, payment review form and supporting documentation to: Cigna Appeals Unit, P.O. Box 188011, Chattanooga, TN 37422.

Medical Necessity External Review

For the external review process applicable to claim coding and bundling edits, please go to the Billing Dispute External Review webpage to download and complete applicable forms. Upon exhaustion of the two-level processes for a medical necessity denial or denials related to experimental or investigational exclusions, providers may have the right to appeal further through the CIGNA HealthCare External Review Program. This provides a review of certain medical necessity appeals and denials based upon experimental, investigational or unproven exclusions by an independent review organization (IRO). If the CIGNA HealthCare member does not pursue an appeal, and the provider employed, or contracted, to perform the First-Level review is of the same specialty as the appealing provider (but not necessarily the same subspecialty), no Second-Level review is required, and the appealing provider may proceed directly to external review. To proceed directly to external review, the provider must submit a form signed by the participant stating that he/she does not intend to pursue his/her own member appeal.

- Submit the external review request to the following address. Under no circumstances should the request be sent directly to the external independent review organization. CIGNA Appeals Unit, P.O. box 188011, Chattanooga, TN 37422.
- Include any additional clinical documentation that was not previously submitted in the First- or Second-Level requests.
- The request will be reviewed by CIGNA HealthCare to ensure that it meets the criteria for an external review (e.g. medical necessity appeal, exhaustion of First- and Second-Level review process, as applicable).
- CIGNA HealthCare will send an authorization form that must be completed by the provider. In the authorization form, choose which IRO you wish to have handle the appeal. If you do no select an IRO, CIGNA HealthCare will select one for you.
- Upon receipt of the authorization form, CIGNA HealthCare will send its appeal file to the IRO vendor for review.
- The IRO will return its decision to CIGNA HealthCare within 30 days, and this decision will be forwarded to you.
- Approvals will be processed by CIGNA Healthcare within 10 days of receipt of the IRO decision.

Important forms:

- Dispute Resolution Request
- Professional Payment Review

HUMANA

Participating Provider Claim Reconsiderations/Appeals - All Products (full details here and in the Provider Manual)

Level 1 - Claim Reconsideration
• Call Humana Customer Service Provider Call Center (PCC) at 1-800-448-6262
• A 12-digit call reference number will be issued to you by the CS Representative
• Write down the call reference number in order to source it later
• If the initial inquiry with the PCC was not satisfactorily addressed, you may escalate the disputed claim(s) for additional research, and/or performance of “root cause analysis”

Level 2 - Escalation

• Send an encrypted or otherwise HIPAA compliant email to the Provider Concierge Unit (PCU) at Humanaproviderservices@humana.com. Provide the claim information using the Claim Submission Form or provide the details in the body of your email to include the following:
  o The call reference # issued to you from the Level 1 call
  o Claim # found on the Humana EOB/EORs
  o Member ID#
  o Member name – Last, First
  o Date of service
  o Narrative of your dispute/expected outcome
  o Any attachments
  o Your contact information (email address/telephone #)
• Within 3-10 business days you will receive an “Acknowledgement of Submission” email from Humana Provider Services with a 12-digit tracking reference number. If you do not receive an acknowledgement email by the 10th business, resend the email. Please allow the PCU Specialist 30-45 days from the date of the “Acknowledgement” notice to perform research and respond via email concerning your inquiry and submission. If you disagree with the findings, you may reply within 10 days. Replies later than 10 days will likely result in a new case.

Non-Participating Provider Claim Reconsiderations/Appeals

• Medicare:

  Humana Grievances & Appeals  
  P.O. Box 14165  
  Lexington, KY 40512-4165  
  Expedited Fax: 1-800-949-2961

• Medicaid/Dual Eligibles/Commercial:

  Humana Grievances & Appeals  
  P.O. Box 14546  
  Lexington, KY 40512-4546  
  Medicaid/Duals Expedited Fax: 1-855-336-6220
Payment Integrity Inquiries (Recoupments, Financial Recovery Reviews, and Medical Records Requests)

Leave a message for the Humana Provider Payment Integrity Customer Care Team at 1-800-438-7885 with the following information:

- Patient name
- Member identification number
- Date of service
- Claim number
- Recovery identification number
- Reason for your call

A representative will respond via phone within three business days and issue a reference number (Please make note of this reference number for future interactions). If you disagree with the determination, ask for a supervisor. Based on availability, you will either be connected to a supervisor, or a supervisor will contact you within 48 hours of your request (If you would prefer to be contacted via email, please leave your email address on the recording.)

Clinical Audits

Health care providers have the right to appeal the results of audits performed by Humana or Humana’s third-party vendors. A provider has three opportunities to appeal Humana clinical audit findings once the initial over-payment determination is made. Appeal outcomes are generally provided within 60 days. Go to the Humana website for more information on appeals and reconsiderations.

All Level 1, 2, and 3 disputes should be sent to the address or fax below unless there is a specific address indicated in the outcome letter. Please include a copy of the dispute request form along with the original findings letter, previous dispute outcome letters and any other documentation that supports your dispute.

Humana Financial Recovery Clinical Audit Disputes
P.O. Box 14279
Lexington, KY 40512
Fax: 1-888-815-8912

Level 1

Health care providers will receive a final notice from Humana within 45 days of the date of the findings letter detailing the over-payment amount. Providers wishing to appeal the findings must:

- Submit a formal written “Level 1” appeal letter along with all relevant documents within 60 calendar days from the date of the notice to avoid recoupment
- Claims will be reviewed by licensed personnel appropriate for the claim type (professional coder, physician, RN, or pharmacist).

Level 2

Health care providers can respond to the "Level 1” outcome letter by submitting a written “Level 2” appeal request.

- Submit a formal written "Level 2” appeal letter within 60 days from the date on the "Level 1” outcome letter. Include any supporting documentation not previously submitted.
The "Level 2" appeal is sent to a third-party vendor, different from the one that conducted the initial claim review, and conducts similar audits for the Centers for Medicare and Medicaid Services.

The over-payment is placed on hold so that monies are not recouped or offset from future payment until the appeal is resolved.

**Level 3**
Health care providers can respond to the "Level 2" outcome letter by submitting a written "Level 3" appeal request.

- Submit a formal written "Level 3" appeal letter within 60 days from the date of the "Level 2" outcome. Include any supporting documentation not previously submitted.
- The internal clinical physician review team or the internal coding team will conduct the review depending on the type of audit and expertise required.

Note: A physician will review all medical necessity cases.

**Coding Inquiries/Disputes:**
If you wish to dispute, gain a better understanding of or be given an explanation/rationale to a code edit determination applied to a claim line (or lines), please follow this process:

- Call the Humana Customer Service Provider Call Center (PCC) at 1-800-448-6262 and make note of the 12-digit call reference number
- If the PCC Associate quoted information you disagree with, consider insufficient, or need further explanation/rationale and review provided by a certified coder, then please ask the PCC Associate to route the inquiry/issue to the Escalated Code Edit (ECE) team.
- The inquiry will be routed to a certified coder for research, and once completed, the coder will call you to discuss findings, along any subsequent action taken, if applicable and/or eligible.

**MEDICARE**

Medicare has five levels for their [Part A and Part B appeals process](#).

**Level 1 - Redetermination**

- 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination.
- Decision within 60 days of receipt of the request for re-determination. You will receive notice of the decision via a Medicare Re-determination Notice (MRN).
- [Redetermination Request Form](#)

**Level 2 - Reconsideration**
• 180 days of receipt of the MRN or RA.
• Decision to all parties issued within 60 days of receipt of the request for reconsideration.
• Reconsideration Request Form

Level 3 - Administrative Law Judge (ALJ) Hearing

• File a request for an ALJ hearing within 60 days of receipt of the reconsideration decision letter or after the expiration of the reconsideration period (if you do not receive a decision).
• Due to an overwhelming number of new requests and the existing workload, new requests received after April 1, 2013 for ALJ hearing assignment have been delayed. If 22 weeks have not lapsed since your initial ALJ hearing submission request, do not resubmit your request.
• Request for Hearing Form

Level 4 - Medicare Appeals Council Review

• File your request for Medicare Appeals Council review within 60 days of receipt of the ALJ’s decision or after the ALJ ruling timeframe expires (if you do not receive a decision).
• Appeals Council issues a decision within 90 days from receipt of a request for review of an ALJ decision. If the Appeals Council review stems from an escalated appeal, then the Appeals Council has 180 days from the date of receipt of the request for escalation to issue a decision.
• Appeal Form

Level 5 - Judicial Review in U.S. District Court

• Must file a request for judicial review within 60 days of receipt of the Appeals Council’s decision or after the Appeals Council ruling timeframe expires (if you do not receive a decision).
• No statutory time limit on decision.
• To get a judicial review in federal district court, the amount of your case must meet a minimum dollar amount. For 2016, the minimum dollar amount is $1,500. You may be able to combine claims to meet this dollar amount. Follow the directions in the MAC's decision letter you got in level 4 to file a complaint.

For more information please visit the CMS Appeals page.

UNITED HEALTHCARE

United Healthcare has a two-level process for claim reconsideration and appeals.

Level 1 - Claim Reconsideration

• A Claim Reconsideration Request must be submitted within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).
• Physicians and/or staff may submit a Claim Reconsideration Request electronically on Optum Cloud, or by mailing the Claim Reconsideration Request form.
• If submitting online and attachments are not needed, go to UnitedHealthcareOnline.com, select Claims & Payments, select Claim Reconsideration and you will be prompted to log into your account. If submitting online and attachments are needed, use the Optum Cloud Dashboard and you may log into your account.
• If mailing the form, send the Claim Reconsideration Request Form to the claim address on the back of the Customer’s health care ID card.
• To request an adjustment for a claim that does not require written documentation via phone, call (877) 842-3210.

If the request for a claim reconsideration is for a commercial or Medicare member and is to be mailed rather than submitted electronically, send the paper form to the address on the Explanation of Benefits (EOB) or the Provider Remittance Advice (PRA), or claim address on the back of the member’s ID card.

For United Healthcare Empire Plan, send the Claim Reconsideration Request to: P.O. Box 1600, Kingston, NY 12402-1600.

For United Healthcare Community Plan, if the request for a claim reconsideration is for a Medicaid/Chip member, send the form to: United Healthcare Community Plan, P.O. Box 31350, Salt Lake City UT 84131-0530.

Level 2 - Claim Appeal
If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may submit a formal appeal request.
Submit formal appeal request to: United Healthcare Provider Appeals, P.O. Box 30559, Salt Lake City, UT 84130-0575.

• Request must be submitted within 12 months (or as required by law or your participation agreement), from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).
• Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review.

If appealing a claim that was denied because filing was not timely:

• Electronic claims - include confirmation that United Healthcare or one of its affiliates received and accepted your claim
• Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

All proof of timely filing must also include documentation that the claim is for the correct Customer and the correct date of service.

If you are disputing a refund request, please send your letter of appeal to the address noted on the refund request letter. Your appeal must be received within 30 calendar days of the date of the refund request letter, or as required by law or your participation agreement, to allow sufficient time for processing the appeal, and to avoid possible offset of the overpayment against future claim payments. When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe United Healthcare has made the refund request in error.

ERISA (Self-Funded Plans)
Certain health benefits fall under ERISA's jurisdiction. If the employer is responsible for paying the employees' health claims and the health plan is only responsible for administering the benefits, then the plan is considered "self-funded" and falls under ERISA regulations. If your appeal efforts have been exhausted with the payer and you feel the plan is in violation of the Summary Plan Description (SPD), or ERISA, you can file an appeal with the Department of Labor Employee Benefits Security Administration (EBSA).

**APPEAL TEMPLATE LETTERS**

The American Medical Association (AMA) created the following sample claims management and appeal letters. These letters are grouped by category for easier identification.

**Authorization & Eligibility**
- Letter confirming eligibility
- Prior authorization not disclosed
- Referral absent letter

**Contractual Obligation**
- Claims underpayment letter
- PPO discount taken when a contract does not exist

**Medical Necessity**
- Medical necessity denial letter - Option A
- Medical necessity denial letter - Option B
- Letter to patient to notify of appeal

**Payer-applied Edits**
- Modifier 25 denial letter
- Modifier 59 denial letter
- E & M down-coding letter
- CPT® code sets denial letter

**Prompt Payment**
- Late payment letter to health insurer
- Late payment letter to state insurance commissioner or other regulator
- Late payment letter to patient's employer or health plan sponsor
- Late payment letter in violation of contract terms to health insurer
- Timely filing letter

**General**
- Generic appeal letter
- Inadvertent coding error by physician practice letter
- Letter to health insurer or other payer regarding use of an unapproved method of payment for services
- Letter to request contracted fee schedule
- Letter notifying insurers of over-payment
- Letter indicating payment to patient and disclaiming further refund obligation