Aetna Better Health of Kentucky

# Tip Tuesday

We here at Aetna Better Health value your partnership and welcome the opportunity to learn from you and hear your feedback as professionals who have long-standing expertise in service to communities.

**The bottom line is - - - We are here to support you. We hope to provide value and guidance in the navigation of the Medicaid system. Additionally, we want to -- alongside you-- provide services to our men, women, children, and families to achieve common positive health and wellness goals.**

# Appeal or Grievance?
# A closer look.

Just remember, an internal appeal much be filed before an External Review. External review cannot happen after a grievance.

A provider **grievance** is a "complaint about an action taken regarding a member's health plan benefits" and "be sure to tell us you are filing a grievance."

A provider **appeal** is the provider's right to have an adverse determination we made reviewed pursuant to 907 KAR 17:015.

**External reviews** are if you do not agree with the appeal decision you have a right to a third-party review.

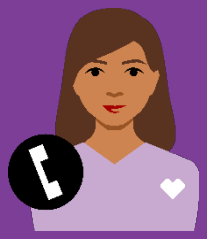
Below are regulation provided for additional reference:

There is no right to an external review following a grievance. KRS 205.646(2) provides for an external review for a provider who has exhausted the "internal appeals process". It does not provide a right to an external review following a decision on a grievance. The accompanying external review regulation, 907 KAR 17:035 states that if an MCO issues an adverse final decision of a denial of a service or claim for reimbursement **as referenced in KRS 205.646(2),** the MCO shall notify the provider of the right to an external review. Section 2 of the regulation states the external review request must be made within 60 days of the MCO's decision resulting from the "internal appeal process." Section 6 states that the department shall deny a request for external review if a party fails to exhaust the "MCO's internal appeal process."

An "appeal" is defined in 907 KAR 17:005(1)(4) as a request for review of an adverse action or decision by an MCO relating to a covered service. The federal regulation states an appeal is a review by an MCO of an adverse benefit determination. 42 CFR 438.400(b). "Adverse benefit determination" is defined by the federal regulation to cover any of the following: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

A grievance is defined in 907 KAR 17:005(1)(30) as that which is defined in 42 CFR 438.400(b). The federal regulation, 42 CFR 438.400(b) defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination.

**Questions? We've got your back.**
**Just call our Network Relations Department at 1-855-454-0061 or contact your Network Manager directly at any time**



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