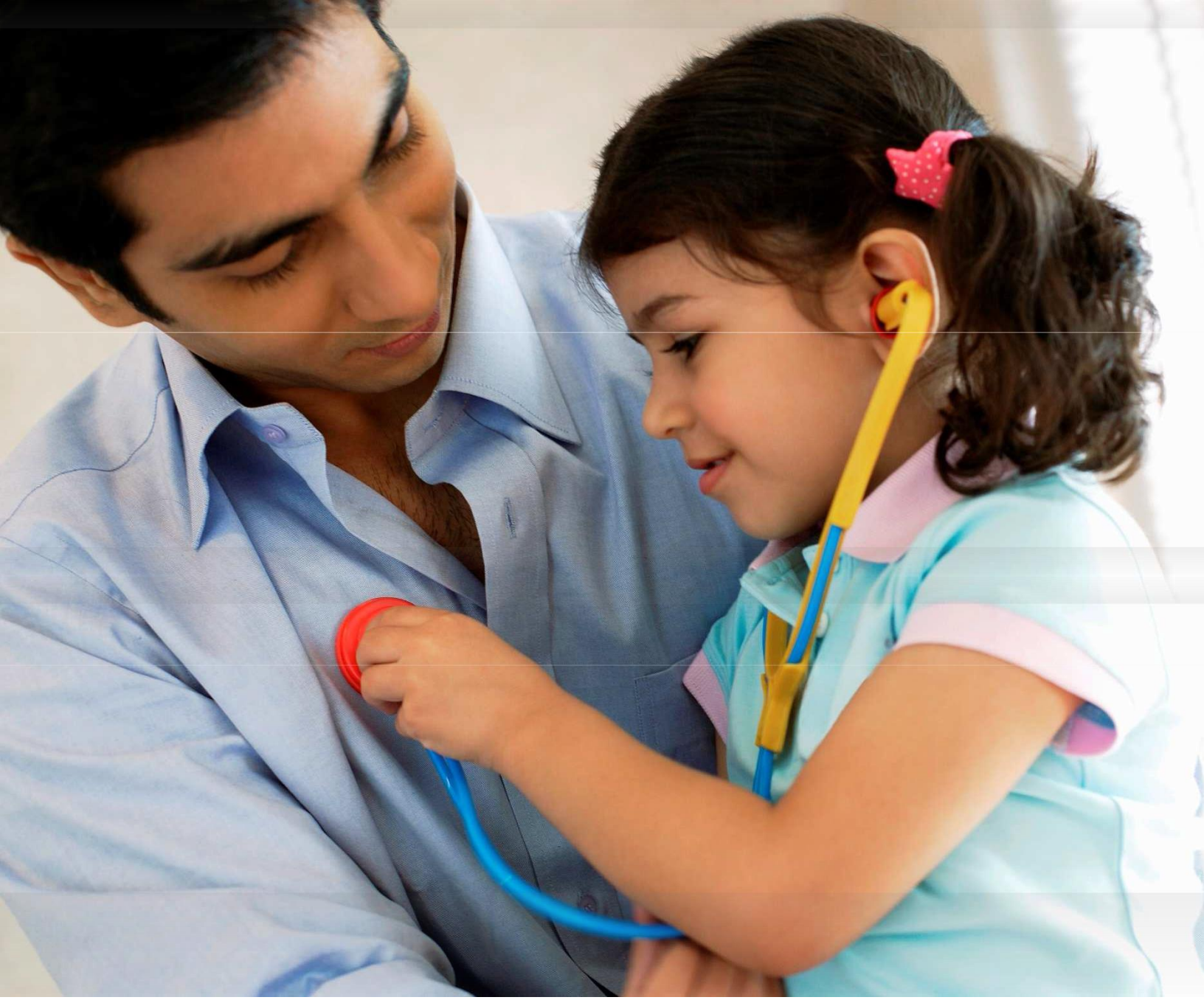


Aetna Better Health® of West Virginia

New Provider Welcome Packet

We are bringing our Network closer together!

WELCOMEPACKET

aetna®

Aetna Better Health® of West Virginia

FIRST:

- Sign up for **Availity** which is our online provider portal. Each TIN will have one account with a primary administrator. The primary administrator can add authorized representatives within the office to their account as users of the portal.
  - Go here: https://apps.availity.com/web/onboarding/availity-fr-ui/#/login and click on "*Create a Free Account*" and follow the instructions.
  - Availity will provide you with many tools:
    - Search member eligibility and verify enrollment
    - Search claims submitted and their status
    - View claim detail, explanation of benefits and remittance advice
    - Contact the health plan via secure messaging
    - If you are a PCP, print your panel roster of Aetna Better Health® West Virginia members
    - Submit claim reconsiderations
    - Submit medical records or itemized bills
    - Run various reports
    - Access to Resources and updates on issues that affect you
  - Availity provides technical support for their portal at **1-800-AVAILITY**.

SECOND:

- If you are not already signed up for Electronic Funds Transfer (EFT) which is a direct deposit set-up, and Electronic Remittance Advice (ERA), your Remits will be on the Provider Portal, go to: https://payerpayments.changehealthcare.com/ to register.
  - You should work with your clearinghouse to ensure you can receive ERA and have the correct file paths
  - Three remit cycles per week

THEN:

- Review the attached pages for more valuable information

ATTACHMENTS

Aetna Better Health® of West Virginia

AETNA BETTER HEALTH® OF WEST VIRGINIA

Quick Reference Guide

Effective: July 1, 2024

Health plan main office	Provider relations phone/fax/email
500 Virginia Street, East Suite 400 Charleston, WV 25301	Phone: 1-888-348-2922 Fax: 1-866-810-8476 ABHWV-ProviderRelations@aetna.com
Hours of operation	**Member services phone/fax/email**
Monday – Friday 8:30 AM – 5:00 PM EST	Phone: 1-888-348-2922 Fax: 1-844-255-7027 ABH-WV-MemberServices@aetna.com
Claims/billing address	**To file a provider appeal**
Aetna Better Health of West Virginia ATTN: Claims P.O. Box 982965 El Paso, TX 79998-2965	Aetna Better Health of West Virginia ATTN: Appeal Coordinator PO Box 81040 5801 Postal Rd Cleveland, OH 44181 **Appeals must be received 90 days from original denial*
Care management phone	**Grievance and appeals fax**
1-888-348-2922	Fax: 1-888-388-1752
Claims payer ID for EDI – Medicaid	**Real time payer ID**
128WV	ABHWV
Behavioral health crisis number	**Health services preauthorization phone**
1-888-348-2922	Phone: 1- 844-835-4930
Vendor phone numbers	**To Request A Peer To Peer Review**
Liberty Dental 1-800-267-6610 eviCore 1-888-693-3211 Eviti 1-888-482-8057 VSP Vision 1-800-877-7195 Modivcare 1-844-549-8353	1-833-459-1998

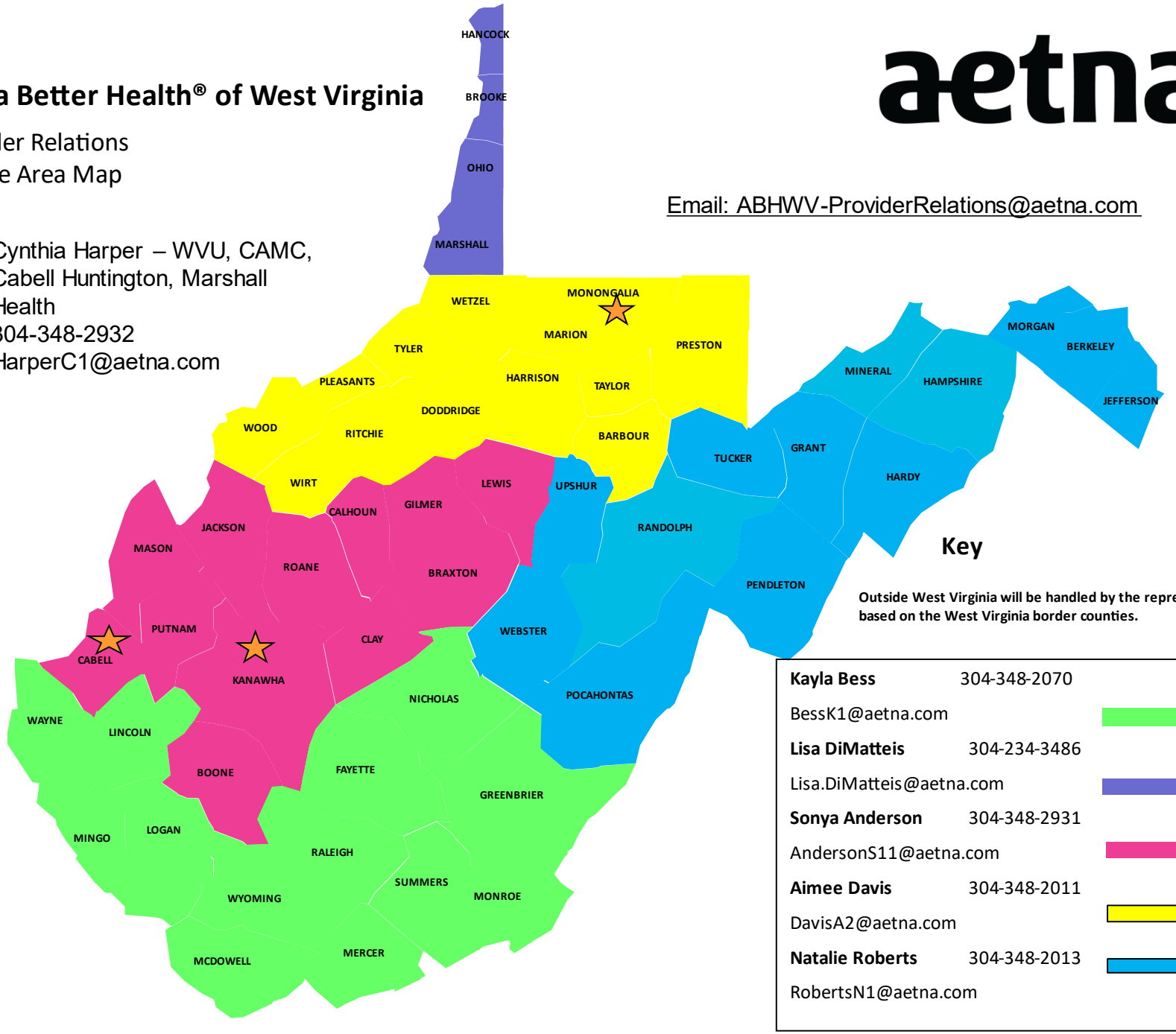
www.aetnabetterhealth.com/wv

Aetna Better Health® of West Virginia

Provider Relations
Service Area Map

Cynthia Harper – WVU, CAMC, Cabell Huntington, Marshall Health
304-348-2932
HarperC1@aetna.com

Email: ABHWV-ProviderRelations@aetna.com



Key

Outside West Virginia will be handled by the representative based on the West Virginia border counties.

Kayla Bess 304-348-2070
BessK1@aetna.com

Lisa DiMatteis 304-234-3486
Lisa.DiMatteis@aetna.com

Sonya Anderson 304-348-2931
AndersonS11@aetna.com

Aimee Davis 304-348-2011
DavisA2@aetna.com

Natalie Roberts 304-348-2013
RobertsN1@aetna.com

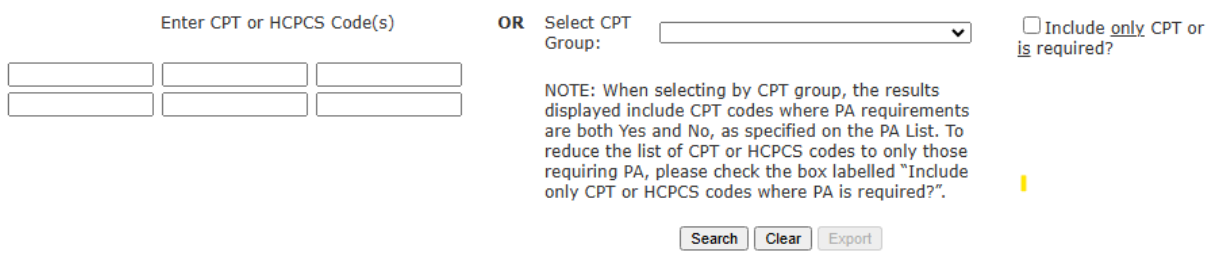
PUBLIC WEBSITE

Aetna Better Health® of West Virginia

NEED HELP? Go online to our public website:
https://www.aetnabetterhealth.com/westvirginia/providers/index.html

You can find the Provider Prior Authorization tool – ProPat:
https://medicaidportal.aetna.com/propat/Default.aspx

You can use this tool to enter CPT or HCPCS codes to see if they require a prior authorization.



You can also find information about:

- **Member Rights & Responsibilities** – Scroll to the bottom of the main page and click on *Member Rights and Responsibilities.*
- **Utilization Management**: How to reach UM staff by phone, how we make decisions, our affirmative statement about incentives and how to obtain UM criteria – You can get there from the *Working with us* tab, then click on *Medical Management*.
- **Clinical Practice and Preventative Guidelines** – You can find these under the Resources tab.
- **Medical Record Review Standards** – Click on the *Resources* tab, then *Materials and Forms*. Click on the *Administration* drop-down.
- **Our Care Management Programs and how to refer members** – Click on the *Working with Us* tab and then *Medical Management.*
- **Available language services and TTY for making referrals -** Click on *Resources*, then *Health equity*.
- Utilize the Search box for other information you are looking for.

PROVIDER RELATIONS

Aetna Better Health® of West Virginia

Aetna Better Health® of West Virginia takes great pride in our network of physicians and related professionals. We want to assist those who serve our members with the highest level of quality care and service. We are committed to making sure our providers receive the best possible information, and the latest technology and tools available. This helps ensure their success in caring for our members.

- Aetna Better Health® of West Virginia has a dedicated staff for Provider Relations that will visit provider offices regularly throughout the year to ensure we are meeting their needs and addressing concerns.
- ***Contact Information for Provider Relations***:
  - Email: ABHWV-ProviderRelations@aetna.com
  - Phone: 1-888-348-2922
  - Fax: 1-866-810-8476
- ***New Provider Orientation Webinar*** – the fourth Thursday of every month at 11:00 am. RSVP to your Provider Relations Representative
- ***Quarterly Existing Provider Education/Updates Webinars*** – Last Thursday of the quarter at 2:00 pm. RSVP to your Provider Relations Representative
- **Aetna Better Health® of West Virginia** will hold ***Provider Workshops*** throughout the state each summer, normally in June or July. These workshops will update you on Medicaid and Health Plan updates.
- ***Provider Relations will:***
  - Provide education to provider offices on a variety of topics
  - Provide support on Medicaid policies and procedures
  - Provide provider contract clarification
  - Assist with demographic changes, terminations and initiation of credentialing
  - Monitor compliance with applicable State and Federal agencies
  - Conduct member provider complaint investigation
  - Maintain the on-line Provider Directory ***(Be sure to update your Provider Relations Representative of all provider changes, location changes, TIN changes, etc.)***
  - Be a point of contact for provider concerns
  - Provider Relations can be reached at 1-888-348-2922
- ***Provider Credentialing***
  - All providers/practitioners MUST first be enrolled with BMS. ***You should not contact us until you have been approved and enrolled with BMS.*** You do not have to accept traditional fee for service Medicaid members.

- Once enrolled with BMS, to initiate our credentialing process of a new provider(s) by using the Provider Data Sheet form found on our website: https://www.aetnabetterhealth.com/westvirginia/providers/join-network.html#acc_link_content_section_accordion_1 ***The provider's CAQH number is required.***

- To check the credentialing status of a provider after 60 business days, you can email your provider relations representative.

Member/Provider – Miscellaneous Information, Resources and Support

- ***Member Services can help assist members and providers with:***
  - Eligibility and benefits
  - Assisting members with available programs and resources
  - Assisting members in finding providers
  - Assisting members in filing grievances or appeals
  - Connecting members with plan resources in Care Management and Quality Management
  - Assist providers in verifying eligibility and benefits
  - You can reach Member Services at 1-888-348-2922
  -

- ***Medical Criteria***
  - Aetna Better Health® of West Virginia will apply Hearst Corporation's MCG evidence based care guidelines (formally Milliman Care Guidelines) effective for medical and behavioral health services as well as Aetna Clinical Policy Bulletins and Aetna Clinical Policy Council Review in that order
  - We will also utilize LOCUS/CASII Guidelines/American Society of Addiction Medicine (ASAM) when applicable
  - Medical criteria information is available on the provider website at https://www.aetnabetterhealth.com/westvirginia/providers/clinical-guidelines-policy-bulletins.html

- ***Community Outreach***
  - Aetna Better Health® of West Virginia has dedicated Community Outreach staff throughout the State of West Virginia
  - Community Outreach works to be visible and accessible local resources for: Members, potential members, Community partners, as well as Community Health Partners
  - Community Outreach staff works with Provider Relations staff to be a backup contact source within each region

- Community Outreach staff presents curriculum on a variety of subjects
  - Personal hygiene (adapted to be age-appropriate in schools)
  - Bullying Prevention
  - Oral Health
  - Nutrition
  - Smoking cessation, and more
- Participate in community events, organizations and meetings that reach members, potential members and community partners
- Provide education and answers about member benefits
- A point of contact for members
- To contact our Community Outreach Department, call 1-888-348-2922
-

➢ ***Provider Manual – Medical and Behavioral Health*** located on website: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/west-virginia/provider/pdf/abhwv_provider_manual.pdf As an Aetna Better Health® of West Virginia provider, there are certain procedures and protocols you need to know. You will find most of the information you need in the Provider Manual.

- Important contact information
- Credentialing/Re-credentialing information
- Which services our plan covers
- Provider Rights and Responsibilities
- How to file a claim
- Grievance and Appeals Processes
- Member Rights and Responsibilities
- Our Utilization and Case Management programs and how to get a member referred
- Quality improvement program
- And information about a wide variety of topics

➢ ***Fraud, Waste & Abuse***

- Aetna Special Investigation Unit (SIU)
  - Monitoring of fraudulent billing practices
  - Verification of services
  - Documentation review
- To report suspected fraud, waste or abuse
  - Call 1-844-405-2016
  - Use the Fraud, Waste & Abuse Reporting Form on www.aetnabetterhealth.com/westvirginia
  - Email us at Aetna@fraudandabuseWV.com

APPOINTMENT ACCESSIBILITY STANDARDS

Aetna Better Health® of West Virginia

- ***Appointment Accessibility Standards***
  - ***PCPs***
    - Regular/Routine PCP (non-urgent) – within 21 calendar days
    - Urgent Care (care for a minor health problem) – within 48 hours
    - Emergency Care (life threatening or severe problem) – Immediately or referred to ER facility.
    - General appointment accessibility – twenty hours per week per practice location
    - Access to after-hours care by a network PCP is available to members 24 hours a day, 7 days a week.
    - After hours calls to the answering service for urgent problems are returned immediately
    - After hours calls to the answering service for non-urgent problems are returned within 30 minutes
  - ***Specialists***
    - New patient initial visit - within 90 calendar days
    - Existing patient follow-up visit – within 30 calendar days
    - Urgent Care (care for minor health problem) – within 48 hours
    - Emergency Care (life threatening or severe problem) – immediately or referred to ER facility.
    - Initial Prenatal – within 14 calendar days of pregnancy confirmation
  - ***Behavioral Health***
    - Initial/Routine Care – within 10 business days
    - Routine/Follow-Up (non-urgent, symptomatic conditions) – within 60 calendar days
    - Urgent Care (no immediate danger to self or others and/or if the situation is not addressed within 48 hours, it may escalate) – within 48 hours
    - Non-Life-Threatening Emergency (no immediate danger to self or others and/or if the situation is not addressed within 6 hours, it may escalate) – within 6 hours
    - Discharge Follow-Up Visit – within 7 calendar days of discharge.

PRIOR AUTHORIZATION

Aetna Better Health® of West Virginia

- You can request Prior Authorizations electronically through Availity only.
- *All services* rendered by Non-PAR providers require Prior Authorization. If you need to refer a member(s) to Non-PAR provider, you MUST get a Prior Authorization
  - ***If prior authorization is not obtained, the referring PAR provider may be held responsible for the charges.***
- For hospital transfers where the move is lateral or non-emergent, make sure that Prior Authorization is obtained before the member is moved.
- Participating providers who are referring to a non-participating provider are required to obtain prior authorization for the services, including ancillary services such as labs/paths, radiology, etc. If prior authorization is not obtained for referral to non-par providers, the par provider making the referral can be contractually held responsible for the non-par provider's bill.

Aetna Better Health® of West Virginia

- Prior Authorization Decision Timeframes:

Decision	Decision timeframe	Notification to	Notification method
Urgent pre-service approval	Based on members need but no more than seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Based on members need but no more than seventy-two (72) hours from receipt of request	Practitioner/Provider and Enrollee	Oral and Electronic/Written
Non-urgent pre-service approval	Based on members need but no more than seven (7) calendar days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	Based on members need but no more than seven (7) calendar days from receipt of the request	Practitioner/Provider and Enrollee	Oral and Electronic/Written

- Peer-to-Peer Review Process. Please call **1-866-389-1667** with your request.
  - For Prior Authorization – the request for a peer-to-peer review must be received within five (5) business days of the date of the denial of coverage determination fax/letter was sent, prior to services being

PRIOR AUTHORIZATION

- rendered, and prior to the receipt of a claim or request for an appeal.
- For Concurrent Review – the request for peer-to-peer review must be received within two (2) business days of the issuance of the verbal denial, independent of the discharge date. For concurrent review peer-to-peer requests that are received more than two (2) business days of the issuance of the verbal denial, practitioners will be advised on the provider appeal process.
  For services that have already begun or have been completed, the request is handled in accordance with the Aetna Better Health provider appeal process.

➢ Prior authorizations for MRI, PET, CT and Interventional Pain Management are obtained through EVICORE.

➢ Authorization can be requested via phone, fax or web portal:
  - Phone 1-888-693-3211
  - Web: https://www.evicore.com

➢ EVITI manages oncology prior authorizations: chemotherapy and radiation.
  - Authorization can be requested at https://connect.eviti.com

CARE MANAGEMENT

Aetna Better Health® of West Virginia

Aetna Better Health® of West Virginia implements a population-based approach to specific chronic diseases or conditions. All Aetna Better Health® members with identified conditions are auto enrolled in our Care Management programs based on claims date. Members that do not wish to participate can call member services and notify the Plan of their desire not to participate and they will be dis-enrolled from the program. The member, family member, caregiver or you, the practitioner, can refer your patient to our Care Management program as well.

All enrollees are sent educational material to promote better member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care, and testing which are supported by evidence-based practices and tools. Additionally, auto alert flags are sent to the care manager's desk top identifying members with significant "gaps" in their care and/or disease/condition. Care managers reach out to those members in an effort to educate and assist the members in obtaining needed services, including, lifestyle modifications and health resource access. The current specialized care management programs include ***Neonatal Abstinence Syndrome, Diabetes, High Risk Obstetrics and Asthma***.

Our goal is to assist and improve our members/your patients with their health literacy so they can better understand their chronic conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Practitioners and providers can contact the Plan at **1-888-348-2922** and follow the prompts to enroll a member in our Care Management program. The chronic conditions managed include diabetes, COPD, asthma, CAD, depression, and heart failure.

The following services are offered by the program:

- Support from health plan nurses and other health care staff to ensure that patients understand how to best manage their condition and periodically evaluate their health status
- Periodic newsletters to keep them informed of the latest information on conditions and their management
- Educational and informational materials that assist patients in understanding and managing medications prescribed by practitioners, how to effectively plan for visits to see practitioners and reminders as to when those visits should occur

Membership in our care management program is voluntary, which means at any time members can request withdrawal from the program - they need only call the health plan's Member Services department.

CLAIMS

Aetna Better Health® of West Virginia

- Provider/Practitioners are required to file complete, accurate and clean claim(s)
- New claim(s) information for Aetna Better Health® of West Virginia
  - **EDI payer ID**
    128WV
  - **Claims mailing address:**
    Aetna Better Health® of West Virginia
    ATTN: Claims Department
    P. O. Box 982965
    El Paso, TX 79998-2965
- Timely Filing Requirements
  - **Initial Claims** - 365 days from date of service or date of discharge for inpatient claims
  - **Corrected Claims** – 120 days from the date of the initial remittance advice to submit corrected claims or to request an adjustment.
    - Label all Corrected Claims as "Corrected Claim" on the claim form
    - Submit all claim lines, not just the line being corrected
    - MUST be submitted with the Dispute Form provided on paper to:
      Aetna Better Health® of West Virginia
      ATTN: Claims Department
      P.O. Box 982965
      El Paso, TX 79998-2965
  - **Resubmitted Claims** – 120 days from the date of the initial remittance advice to resubmit for reconsideration with documentation.
    - When a claim is denied for medical records, you have 90 days from the date of the initial remittance advice requesting same to submit
    - **Resubmission claims with documentation may be submitted electronically through Availity OR** by submitting on paper with the Dispute Form provided to:
      Aetna Better Health® of West Virginia
      ATTN: Claims Department
      P.O. Box 982965
      El Paso, TX 79998-2965
  - ***DO NOT SEND CORRECTED OR RESUBMITTED CLAIMS TO THE LOCAL HEALTH PLAN OFFICE. MUST BE SENT TO THE ABOVE ADDRESS OR IT WILL BE RETURNED TO SUBMITTER.***
  - **These requirements are applicable to all providers, including behavioral health.**

- Aetna Better Health® of WV regularly reviews and analyzes claim composition to identify opportunities for improvement. To that end, we are working with ***Cotiviti Healthcare (Cotiviti)*** to assist us with provider claim reviews and reimbursement review practices. ***Cotiviti*** performs reviews of medical records for services rendered and conducts post payment reviews of medical claims.

  As a provider for Aetna Better Health® of WV, you may receive communication from ***Cotiviti*** requesting additional information or sharing our findings pertaining to those reviews.

  Questions?
  If you have any questions about this review process, simply call Aetna Better Health® of West Virginia's Provider Relations Department at **1-888-348-2922.** You can reach us Monday through Friday, 8 am to 5 pm

- For claim status or questions, please contact Claims Inquiry/Claims Research by calling 1-888-348-2922

Claims Inquiry/Claims Research (CICR) – 1(888)348-2922

- Assist with claims questions, status', inquiries and disputes
- Review Claims or remittance advice(s)
- Assist with claim related prior authorization questions
- View recent updates
- Locate forms
- Assist with changes to a practice/practitioner/group's demographics (locations, provider termination, etc.)

Appeals

The provider appeal process is a formal mechanism that allows the Provider the right to appeal the health plan's decision. Before filing an appeal regarding a claim, providers should exhaust the Claims Dispute Process

- PAR provider appeals MUST be received within ninety (90) days of the action taken by Aetna Better Health of West Virginia, giving rise to the appeal
- The appeal letter should clearly note you are filing an ***"Appeal"***
- All documents to support the appeal should be provided, such as a copy of the claim, remittance advice, medical review sheet, medical records and correspondence
- Claims editing denials are **NOT** subject to appeal

- Submit Appeal via
  - Fax: 1-888-388-1752 or
  - Mail: Aetna Better Health® of West Virginia
    ATTN: Appeal Coordinator
    PO Box 81040
    5801 Postal Rd
    Cleveland, OH 44181
- Decision response is within thirty (30) calendar days
- The Appeal decision is the final decision. There are no 2nd level appeals

TO: Provider/Practitioner Billing Office
FROM: Provider Relations Department
RE: ***EDUCATION – Correct/Resubmit/Dispute/Appeal Claim(s) Process***

CORRECTED, RESUBMISSION FOR RECONSIDERATION and DISPUTED CLAIM(S) – *must be submitted within 120 days of the date of the initial Remittance.*

Follow the attached instructions on the appropriate process to file a Corrected Claim or a Resubmission for Reconsideration Claim, as well as any claim Dispute. USE THE ATTACHED FORM WHEN SENDING IN THESE CLAIMS.

A Corrected Claim(s) and Resubmitted Claim(s) with attached Medical Documentation ***MUST be sent to***:

Aetna Better Health of West Virginia
ATTN: RESUBMITTED CLAIMS
P.O. Box 982965
El Paso, TX 79998-2965

NOTE: If these Claim(s) are sent to the Charleston, WV, office, they will be returned to you twice to educate you on the process. If they are sent to the Charleston office after the second education, then these claim(s) will be shredded and destroyed.

ONLY RESUBMITTED CLAIMS with medical documentation can also be sent via Availity. How-To directions are attached.

A Disputed Claim(s) ***MUST BE SENT TO***: (NO MEDICAL DOCUMENTATION ATTACHED)

Aetna Better Health of West Virginia
ATTN: Provider Relations Department
500 Virginia Street, East, Suite 400
Charleston, WV 25301

NOTE:

- ***NON-Participating Providers MUST get Prior Authorization to treat our member(s). In an emergency situation, you have 48 hours to contact us to obtain a Prior Authorization to treat our member(s).***
- ***Participating Providers who refer to NON-Participating Providers, including ancillary services such as labs/path, radiology, etc., MUST get a Prior Authorization. If Participating Provider does not obtain a Prior Authorization to refer to a NON-Participating Provider, the Participating Provider can contractually become responsible for NON-Participating provider's billing.***

SECOND STEP

APPEALS & GRIEVANCES

Non-Participating providers DO NOT have any opportunity to an appeal/grievance.

Participating Providers can file an Appeal/Grievance, but ONLY AFTER you have tried sending the claim as a Dispute. You MUST send appropriate Appeals/Grievances to:

Aetna Better Health of West Virginia
ATTN: Appeal Coordinator
PO Box 81040; 5801 Postal Rd
Cleveland, OH 44181
Or Fax To: 1-888-388-1752

www.aetnabetterhealth.com/westvirginia

Aetna Better Health of WV, Inc.

Provider Resubmission and Appeal Instructions

PLEASE READ CAREFULLY AND FOLLOW THE INSTRUCTIONS INDICATED

A **RESUBMISSION** is defined as a claim originally denied because of incorrect coding (would be a considered a corrected claim) or missing information (would be considered a reconsideration) or that prevents Aetna Better Health from processing the claim. **Practitioners and providers have 120 days from the initial remittance date to resubmit claims and 90 days to appeal a claim.**

CORRECTED CLAIM

- Submit a corrected claim marked at the top of the claim "CORRECTED CLAIM FOR RESUBMISSION" along with the completed *Provider Resubmission and Dispute form*, found on page 5.

Examples of a Corrected Claim:
Newly added modifier
Code changes
Any change to the original claim

CLAIM RECONSIDERATION

- Submit **a claim form** marked at the top "RECONSIDERATION" along with the completed *Provider Resubmission and Dispute form* - blank form attached.
- Submit medical records and/or additional information required to reconsider the claim
- Information should be submitted **single sided**
- Please refer to the provider manual for provider filing timeframes (120 Days from Decision to submit a Request for Reconsideration)
- ***INFO: All NON-PAR providers are required to get a PRIOR AUTHORIZATION to treat our members. Under emergency circumstances, providers have 48 hours to call the Health Plan to obtain a PRIOR AUTHORIZATION. NO RETRO AUTHORIZATIONS will be considered. If a PAR provider refers to a NON-PAR provider, including ancillary services, labs/path, radiology, etc., the PAR provider MUST get a Prior Authorization prior to service. If PAR provider fails to get a Prior Authorization for NON-PAR provider, contractually, the PAR provider can become responsible for the NON-PAR provider's services/billing.***

Examples of Reconsiderations:
Itemized Bill • All claims associated with an Itemized Bill must be broken out per Rev Code to verify charges billed on the UB match the charges billed on the Itemized Bill. (Please attach I-Bill that is broken out by rev code with sub-totals.)

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-888-348-2922 8:30am-5:00pm EST Monday – Friday.. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

Aetna Better Health of WV, Inc.

Duplicate Claim • Review request for a claim whose original reason for denial was “duplicate” • Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed
Coordination of Benefits • Attach EOB or letter from primary carrier
Proof of Timely Filing • For electronically submitted claims provide the second level of acceptance report • Refer to Proof of Timely Filing Requirements in the Aetna Provider Manual
Claim/Coding Edit • We use two (2) claims edit applications: Claim Check and Cotiviti. Please refer to the Aetna Provider Manual for details.

ALL CLAIM RESUBMISSIONS (Corrected Claims and Reconsiderations)

***MUST BE SUBMITTED TO*:** Aetna Better Health of WV, Inc.
ATTN: RECONSIDERATIONS
PO Box 982965
El Paso, TX 79998-2965

OR: You can submit your *Requests for Reconsideration ONLY (NOT CORRECTED CLAIMS)* with supporting documentation through Availity.

An **APPEAL** is defined as a request for review of a claim denial or payment that does not meet one of the items above. Please refer to the Aetna Better Health of WV Provider Manual, located on our website at ABH-WV Provider Website for details.

Examples of Appeals:
Requests for review on your own behalf
Untimely Filing of the Claim • A review of a claim that was submitted outside the timeframe • Provide good cause justification documentation for late filing; OR • For electronically submitted claims provide the second level of acceptance report as proof of timely filing • Refer to Proof of Timely Filing Requirements in the Aetna Provider Manual

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-888-348-2922 8:30am-5:00pm EST Monday – Friday.. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

Untimely Decision Making

- A review of a decision where Aetna did not render the decision on a prior authorization timely
- Provide a copy of the denial showing the received date and the decision date

Dissatisfaction with the resolution of a reconsideration or dispute as applicable

For Medicare Plans:

Non Contracting Providers have the right to appeal a denied claim or the amount paid on the claim.

- Send a written notification of your request with the claim number
- Include any additional information; clinical records or other documentation
- If the claim was denied: Include a signed "Waiver of Liability" (WOL) form
- If you disagree with the payment amount: Include evidence that the claim would have been paid differently under original Medicare.

On Behalf of a Member

- Continued stay concurrent review
- Urgent or Emergent review

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-888-348-2922 8:30am-5:00pm EST Monday – Friday.. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

Aetna Better Health of WV, Inc.

- Pre-Service (Prior Authorization) requests
    - Must have written consent to act on behalf of the member
- When filing on behalf of a member, the request is processed as a **Member Appeal** and is subject to the member appeal policies and timeframes

If any of the above appeal examples apply, please DO NOT use the Resubmission and Dispute form.

Please fax or mail the Appeal and all supporting documentation clearly marked as "ATTN: APPEALS COORDINATOR" to:

Aetna Better Health of WV, Inc.
ATTN: Appeals Coordinator
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

Or Fax to: **1-888-388-1752**

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-888-348-2922 8:30am-5:00pm EST Monday – Friday.. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

aetna®
Aetna Better Health of WV, Inc.

MAKE COPIES FOR FUTURE USE

Provider Resubmission and Dispute Form

Please complete the information below in its entirety and mail with supporting documentation to the designated address. Questions regarding a submission should be directed to Claims Inquiry/Claims Research at 1-888-348-2922.

Please indicate the reason for your request and any pertinent details below:

Type of issue	☐ **Corrected Claim** ☐ **Reconsideration** ☐ **Claim Dispute** ☐ **Other Dispute**
Provider Name:	
Submitter's name:	
Provider Street Address:	
Provider City, State & ZIP	
Provider Phone Number:	
Date(s) of Service	
Remittance Advice Date	
Amount Billed	
Amount Paid	
Claim Number(s)	
Member Name	
Member ID #	

Signature of Sender Date

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-888-348-2922 8:30am-5:00pm EST Monday – Friday.. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

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Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Submissions with Attachments via The Web Portal

A recent enhancement has been made to Aetna Better Health of WV's secure web portal. Effective immediately, you will now be able to submit attachments through the Secure Web Portal. Some key points to keep in mind are:

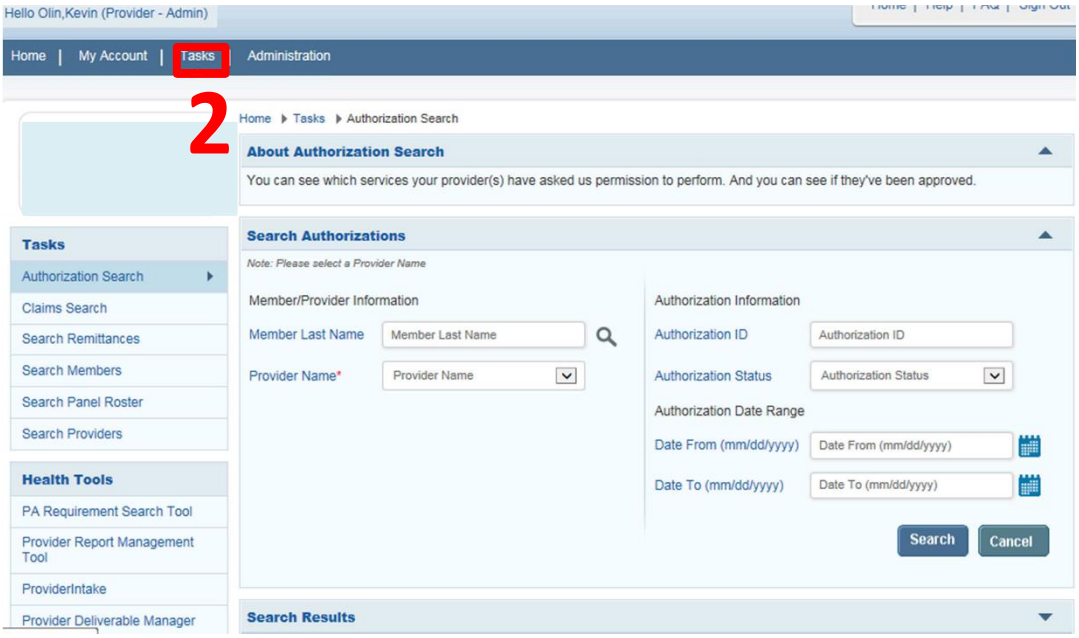
- **Corrected claims are not to be submitted through this process.** Corrected claims must be submitted as they are currently (electronically or through resubmission process. Paper resubmissions GO TO P.O. Box 982965, El Paso, TX 79998-2965). Examples of corrected claims include but are not limited to:
  - Incorrect units billed on the initial claim.
  - Incorrect code information including HCPCS, CPT and ICD-10 codes billed on the initial claim.
  - Incorrect provider information billed on the initial claim.
  - Etc.
- Documents that can be attached are only those listed in the Type of Claims Resubmission drop down field.
- Itemized bills for hospital claims may be attached as an excel file.
- There is a size limit of 3 Mb for any document you may attach. It is recommended to split a file (if greater than 3 Mb) and upload multiple files rather than one large file. We are currently working to resolve and increase the size limitation.
- Once the attachment is submitted, an e-mail is generated to our claims department for claims adjustment. If there are no other issues with the claim, the claim will be processed within 48 – 72 hours from submission.

For your convenience, we are attaching step-by-step instructions for you to follow.

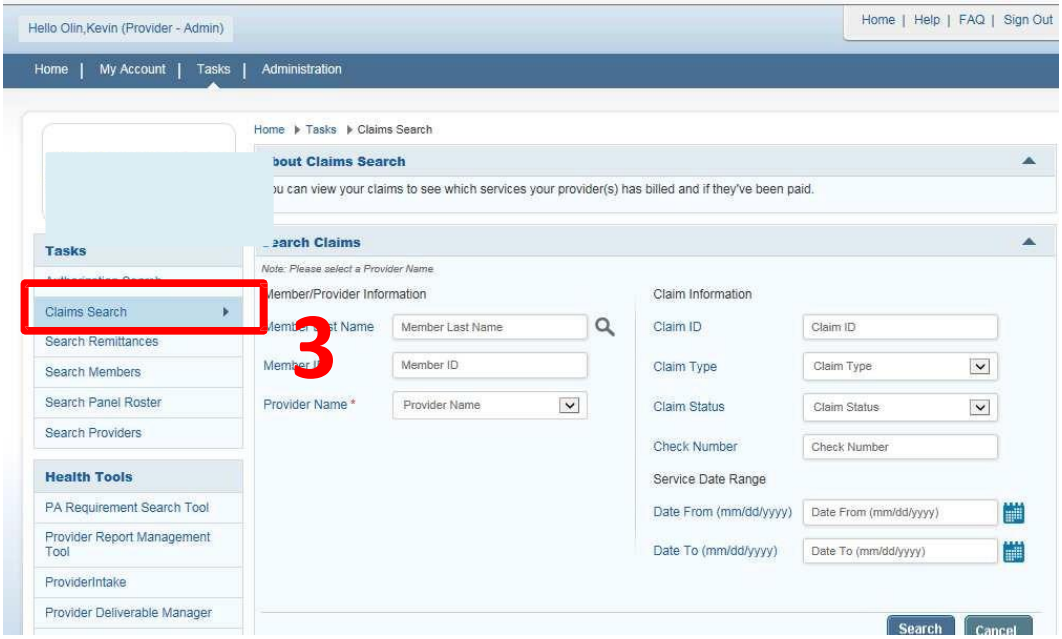
Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Claim resubmission forms from Secure Web Portal screen

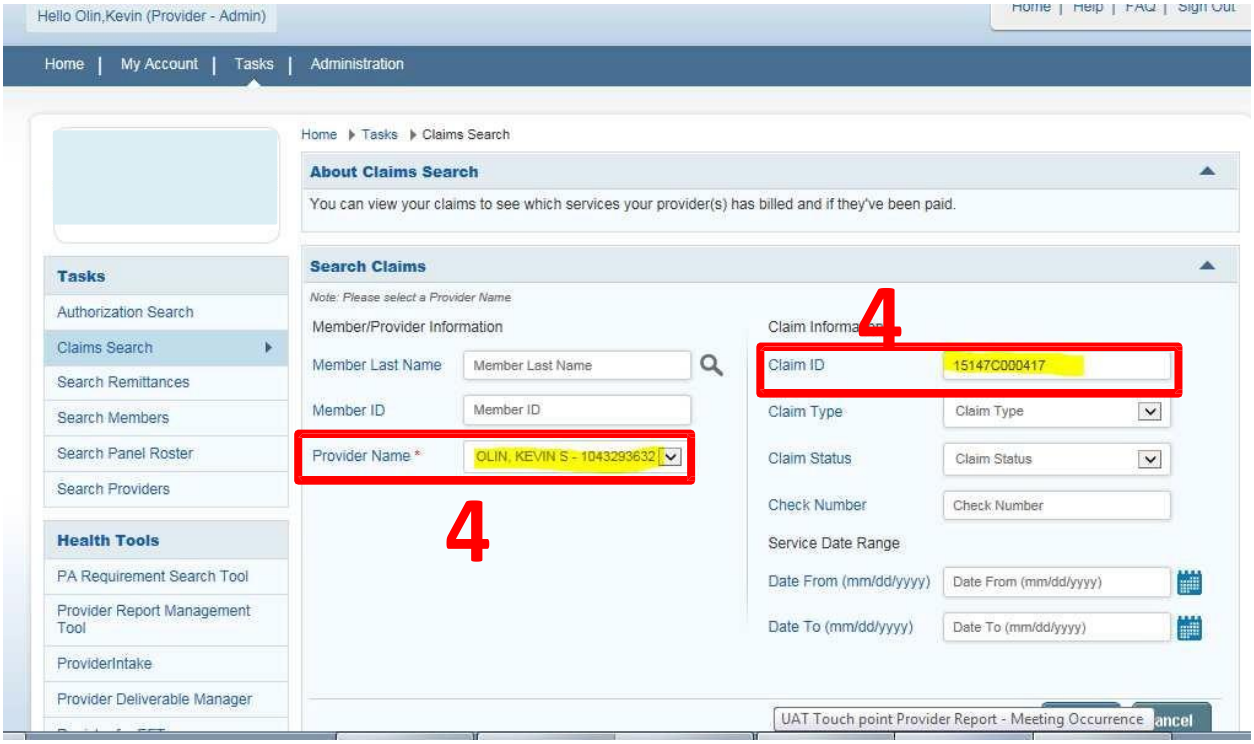
1. The Provider logs into the Aetna Better Health of WV Secure **Web Portal**.
2. Click on **Tasks** from the banner on the top



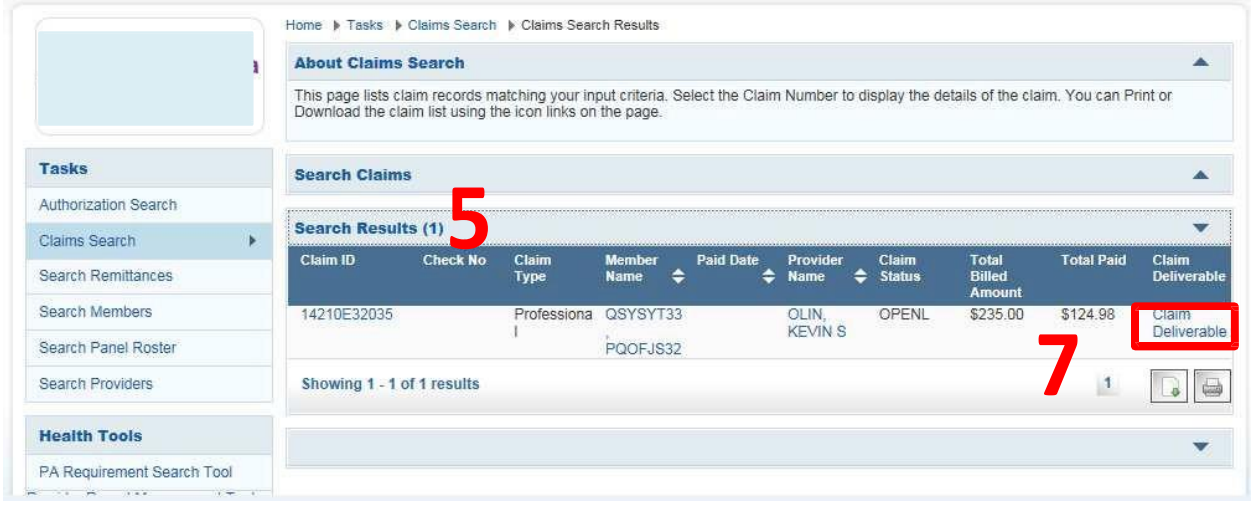
3. Click on **Claims Search** located in the left panel



4. Select **Provider Name** from the dropdown, Enter **Claim ID**, and click the **search** button.

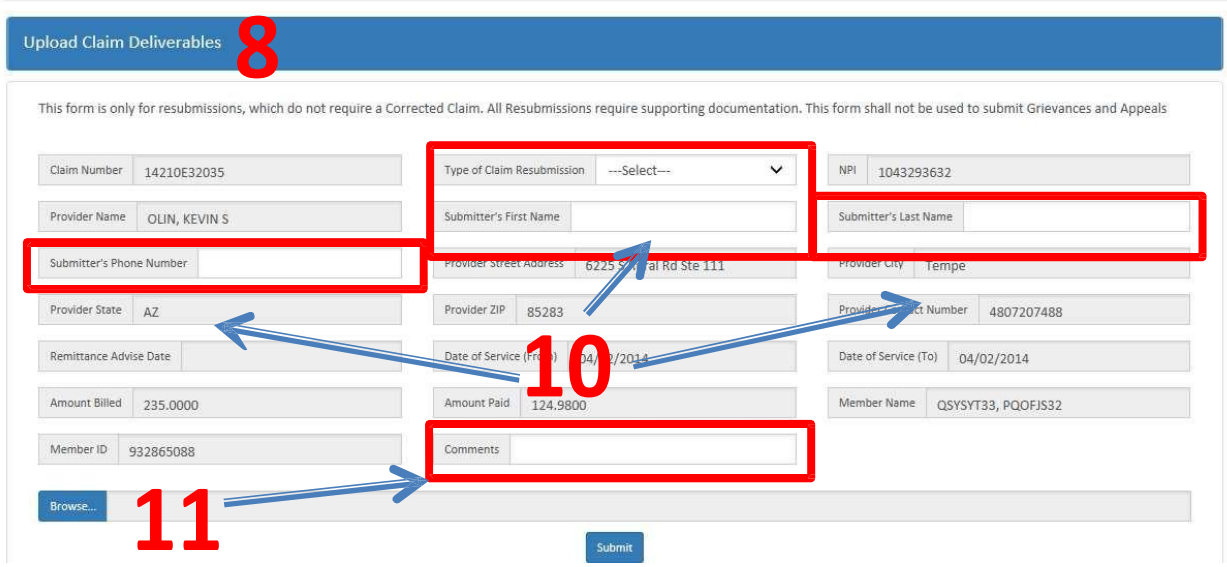


5. The Search results grid will load.
6. The Provider will see **Claim Deliverable** link under the **Claim Deliverable** column in the Search results grid.
7. Click on the **Claim Deliverable** link

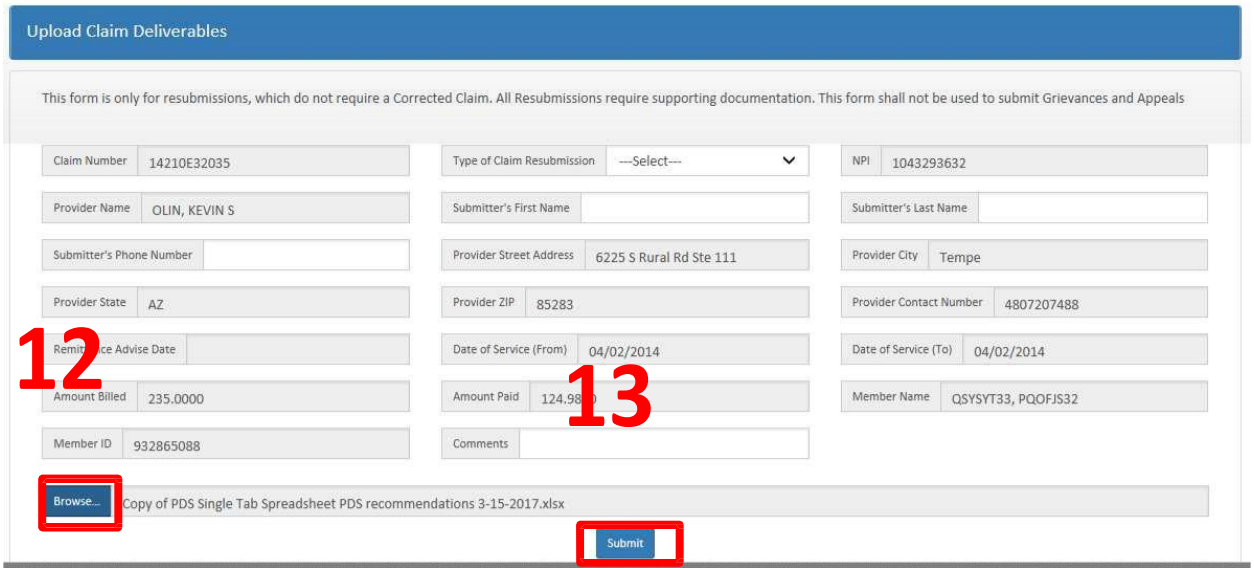


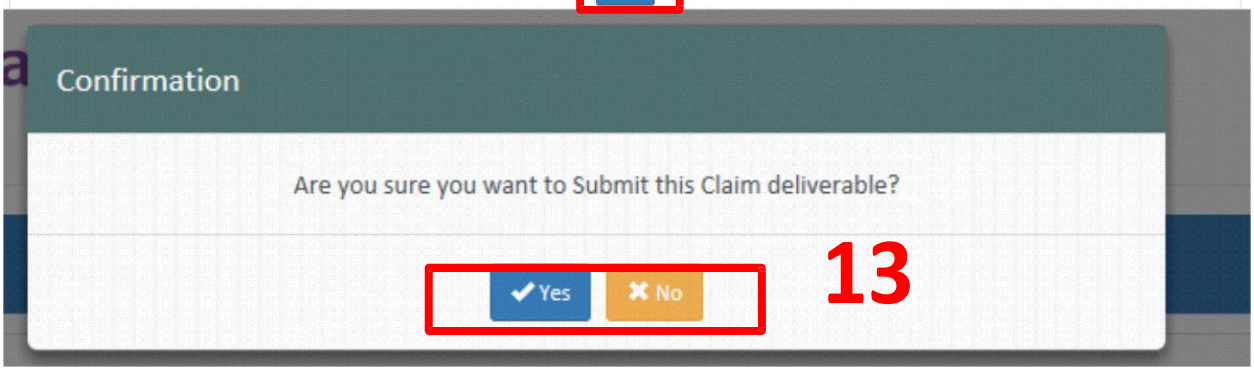
8. This will take the Provider to the **Upload Claim Deliverables** screen.
9. Most of the information on the screen will be 'Auto populated' based on the claim number.

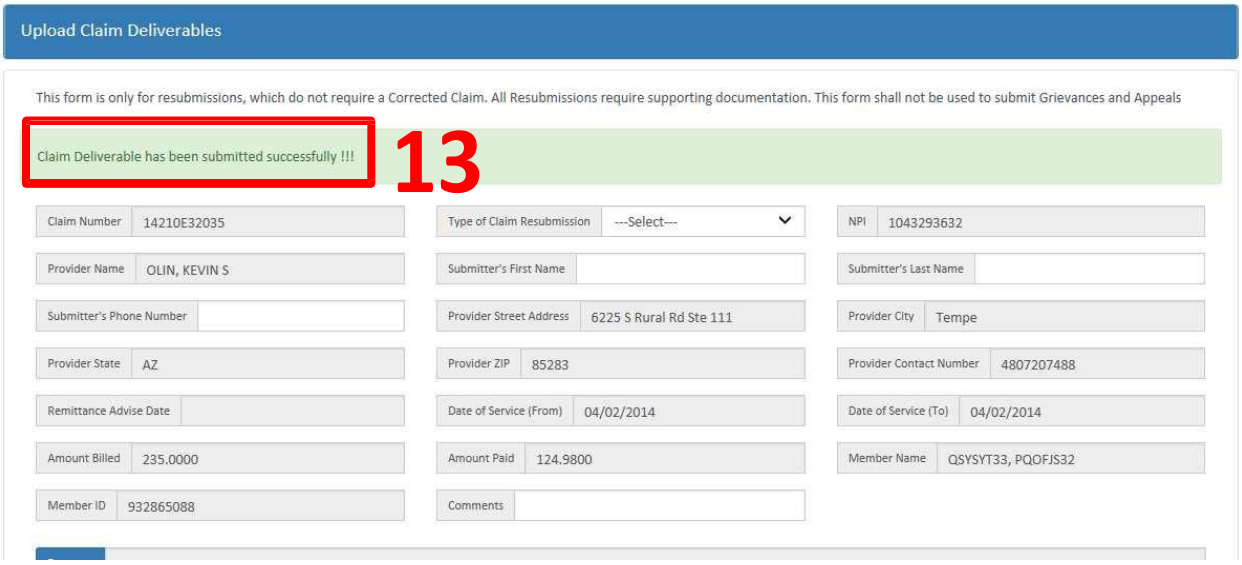
10. Provider will select a **Type of Claim Resubmission** from the dropdown and enters the information in the relevant **Mandatory fields Submitter's First Name, Submitter's Last Name, and Submitter's phone number** fields.
11. The **Comments** field is a mandatory input required, **when** the selected **Type of claim Resubmission** is **Other.**



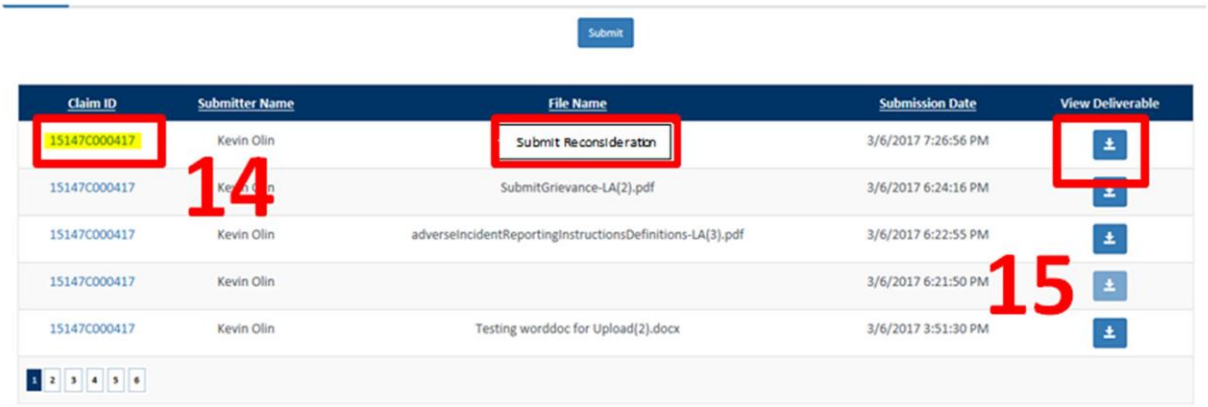
12. The Provider can upload supporting documentation (any type of file) from here through clicking the **Browse** button and thus activating the Browse functionality.
13. On successful attachment of the supporting documentation, the Provider clicks **Submit** and receives a **Confirmation message** window. On clicking **Yes,** the provider receives a success message, completing the workflow for submission.







14. The Provider can view a previously submitted document (any type of file) from the below screen through clicking the link under the **Claim ID** column of the displayed grid, thus activating the **View Deliverable** functionality.



15. The submitted resubmission form is displayed, from where the user can view the previously submitted information on the form and download the attachment by clicking the **Download File** button or through the **Button** below the **View Deliverable** column of the displayed Grid. (Continued in the next page.)

15. Alternatively click **Close** button to exit
16. The provider submission will be notified to claims operations team via a notification
    Note – The Provider has to repeat the process from claim search to upload deliverables for another claim.

HEDIS®

Aetna Better Health® of West Virginia

HEDIS® Toolkit for provider offices

Aetna Better Health® of West Virginia wants you to understand HEDIS® **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et, so our Quality Management Department has put together a HEDIS® Toolkit for our provider offices. You can access our toolkit at: https://www.aetnabetterhealth.com/westvirginia/providers/resources/

NCQA defines HEDIS® as "a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans."

Annual HEDIS® Timeline

February to early May	June	September/October
Quality departent staff collects and review HEDIS® data through on-site provider office chart abstraction and fax requests.	HEDIS® results are certified and reported to NCQA and West Virginia's Bureau for Medical Services (BMS)	NCQA releases Quality Compass results nationwide for Medicaid

NOTE: ***As you know, contractually, we are not responsible for the costs involved in your providing the medical records we request from you. Therefore, when sending our request for medical records to your copy vendors, please communicate with them that NO CHARGES ARE TO BE BILLED TO Aetna Better Health® of West Virginia for records, nor are records to be HELD for payment by Aetna Better Health® of West Virginia. Your copy vendors have HELD records and BILLED for records in the past which will be detrimental to the HEDIS® outcome for your office.***

Remember that HEDIS® is a retrospective process. HEDIS® 2025 = Calendar Year 2024 Data

The Toolkit will provide you with the following valuable information and more:

- Tips and best practices
- Member Incentive Programs
- Describes various Measures for Children, Adults, Women, Chronic Conditions and Behavioral Health
- CAHPS Survey Information
- Physician Documentation Guidelines and correct billing codes