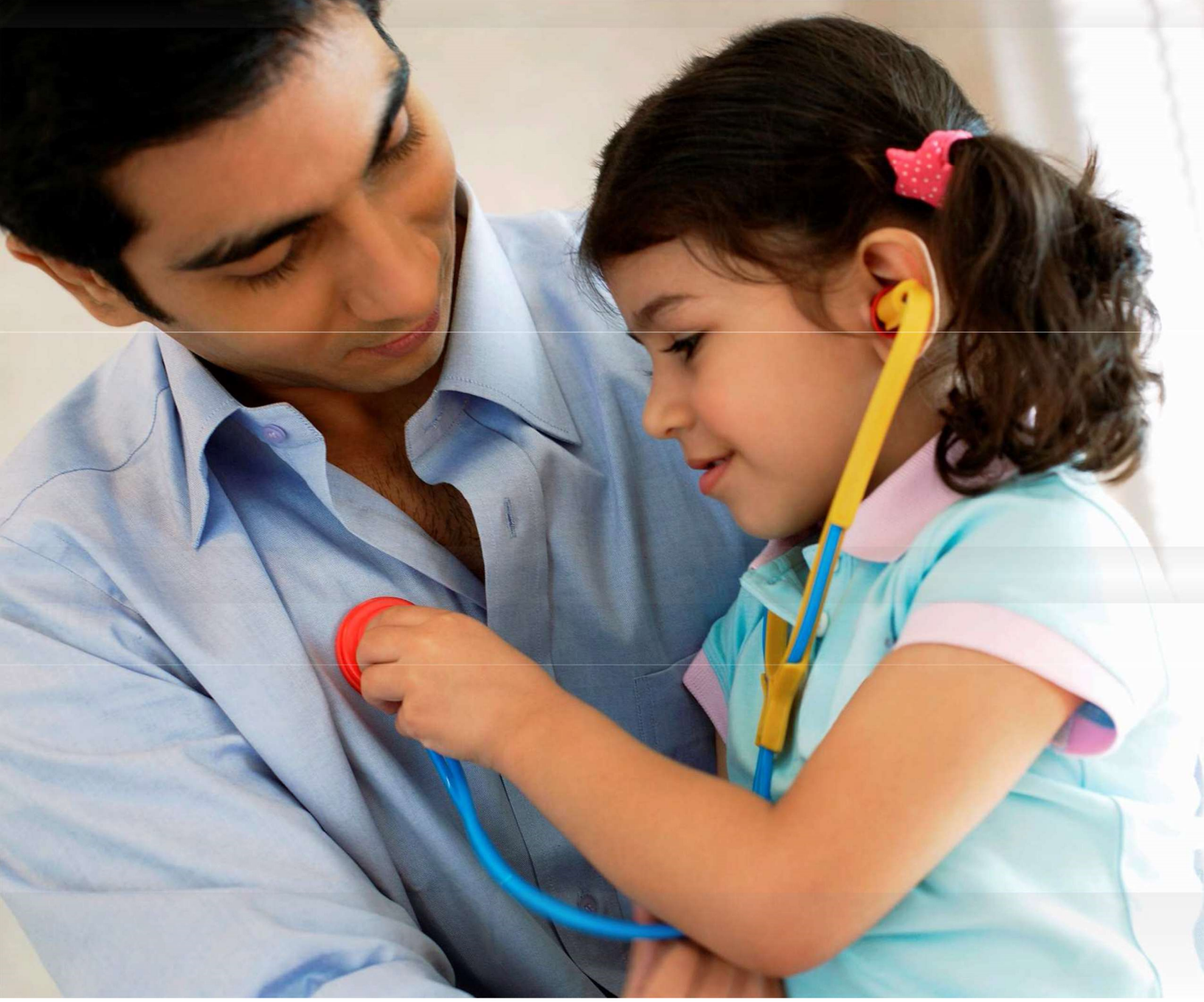


aetna®

Aetna Better Health® of West Virginia

New Provider Welcome Packet

We are bringing our Network closer together!

WELCOME PACKET

FIRST:

- Sign up for the 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://www.aetnabetterhealth.com/westvirginia/providers/portal and click on "*download the form*" (see last paragraphs) and follow the instructions on where and how to submit the form. There is also a downloadable "*Provider Web Portal Instructions*" document.
  - The Provider Portal will provide you with many tools:
    - Search member eligibility and verify enrollment
    - ProPAT/"*PA Requirement Search Tool*" – You can check any CPT or HCPC codes to determine if we require a Prior Authorization for that particular service(s)
    - Review and see all Prior Authorization details and status'
    - 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
    - Search out other in-network Providers for referral purposes. ***(Always refer our members to PAR providers, even for ancillary services, i.e. labs/paths, radiology.***
    - Review HEDIS gaps in care
    - Run various reports
    - Access to Resources and updates on issues that affect you
  - If you would like help registering or would like a demonstration, contact your Provider Relations Representative. (See the Territory Map provided)

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://www.aetnabetterhealth.com/westvirginia/providers/electronic/
  - You should work with your clearinghouse to ensure you can receive ERA and have the correct file paths
  - One Remit cycle per week (Tuesday)

THEN:

- Review the attached pages for more valuable information

ATTACHMENTS

AETNA BETTER HEALTH® OF WEST VIRGINIA

Quick Reference Guide

Effective: July 1, 2019

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 ABH_WV_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 67450 Phoenix, AZ 85082-7450	Aetna Better Health of West Virginia ATTN: Appeal Coordinator 500 Virginia Street, East Suite 400 Charleston, WV 25301 **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/fax**
1-888-348-2922	Phone: 1- 844-835-4930 Fax: 1-866-366-7008
Vendor phone numbers	**To Request A Peer to Peer Review**
Skygen Dental 1-855-844-0623 eviCore 1-888-693-3211 VSP Vision 1-800-877-7195 Logisticare Transportation 1-844-549-8353	1-866-389-1667

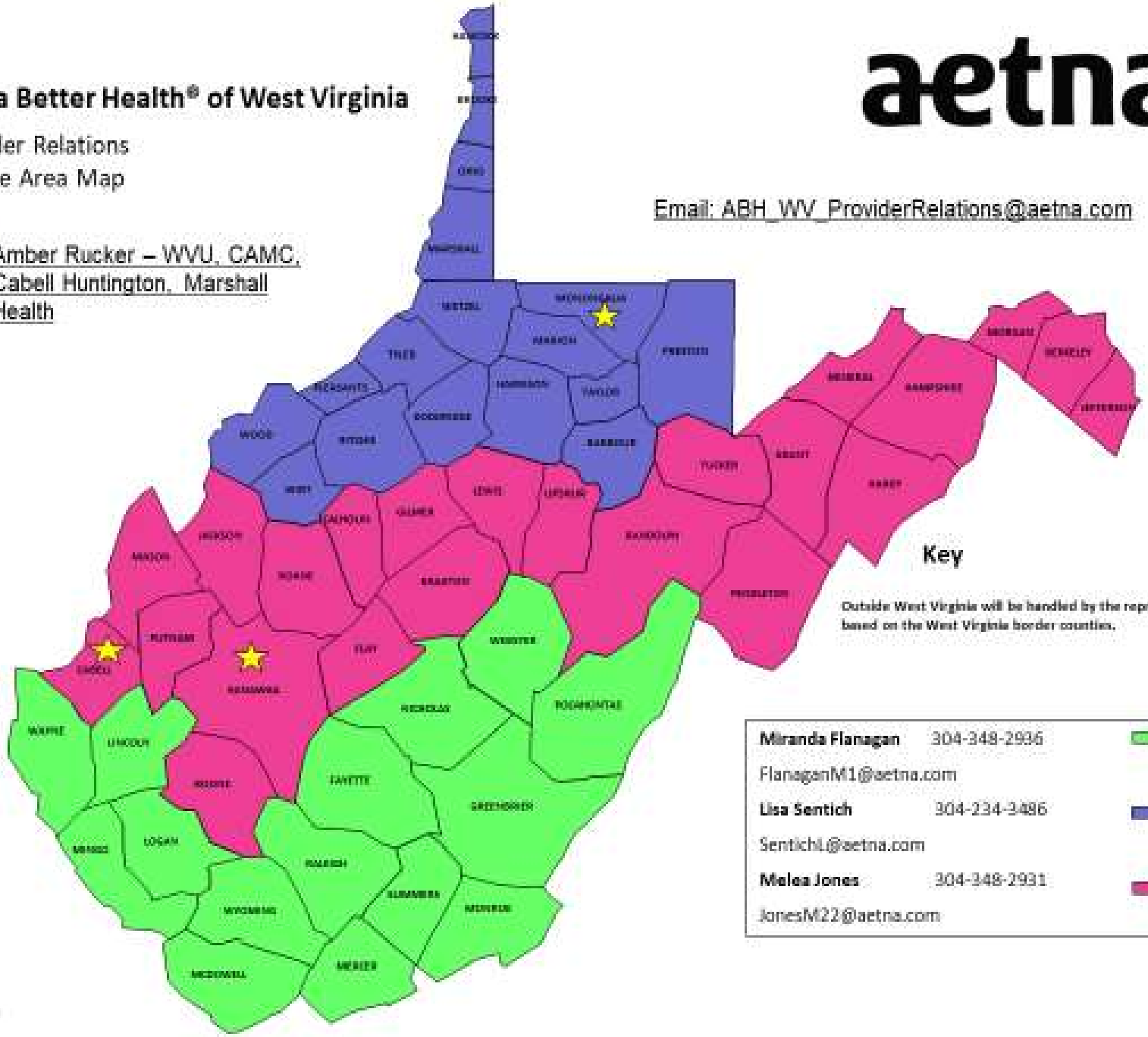
Aetna Better Health® of West Virginia

Provider Relations
Service Area Map

aetna®

Email: ABH_WV_ProviderRelations@aetna.com

★ Amber Rucker – WVU, CAMC, Cabell Huntington, Marshall Health



Key

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

Miranda Flanagan 304-348-2936
FlanaganM1@aetna.com

Lisa Sentich 304-234-3486
SentichL@aetna.com

Melea Jones 304-348-2931
JonesM22@aetna.com

WV-16-05-16

WHAT CAN YOU FIND ON THE WEB?

Need Help? Go online to
www.aetnabetterhealth.com/westvirginia/providers

You can find information about:

- Member Rights & Responsibilities – use the ***Resources*** tab on the left
- Utilization Management: how to reach UM staff by phone and after hours, and how we make decisions, our affirmative statement about incentives and how to obtain UM criteria – use the ***Authorizations*** tab on the left
- Clinical Practice and Preventative Guidelines – use the ***Practice Guidelines*** tab on the left
- Medical Record Review Standards – use the ***Resources*** tab on the left, then click on the purple ***Resources and Information tab***
- Our Care Management Programs and how to make referrals – use the ***Resources*** tab on the left, then click on the ***Special Programs*** tab
- Available language services and TTY for making referrals
- Utilize the Search box for other information you are looking for

PROVIDER RELATIONS

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: ABH_WV_ProviderRelations@aetna.com
  - Phone: 1-888-348-2922
  - Fax: 1-866-810-8476
- ***New Provider Orientation Webinar*** – the last Thursday of every month at 11:00 am. RSVP to your Provider Relations Representative
- ***Quarterly Existing Provider Education/Updates Webinars*** – the last Thursday of every 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 Representatives also will be at all ***State Workshops*** held each Spring and Fall. We will always have a table at these Workshops and have our Provider Relations representatives there to meet you and answer any questions you have.
- ***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***
  - The Aetna Better Health® of West Virginia credentialing process is monitored by the Provider Relations Department

- 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-our-network/. ***The provider's CAQH number is required.***
- To check the credentialing status of a provider after 60 business days, email your request with the Name and Provider NPI # to: ABH_WV_ProviderRelations@aetna.com

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/resources/
- ***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: www.aetnabetterhealth.com/westvirginia/providers/provider-manual
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

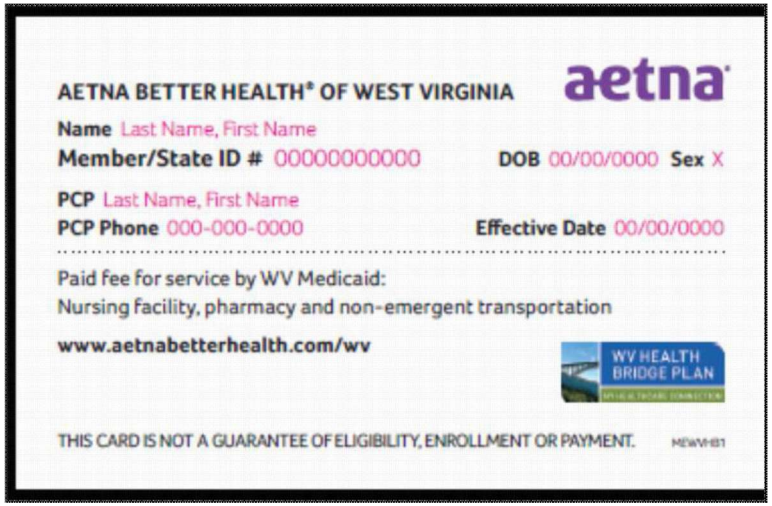
➢ ***Fraud, Waste & Abuse***

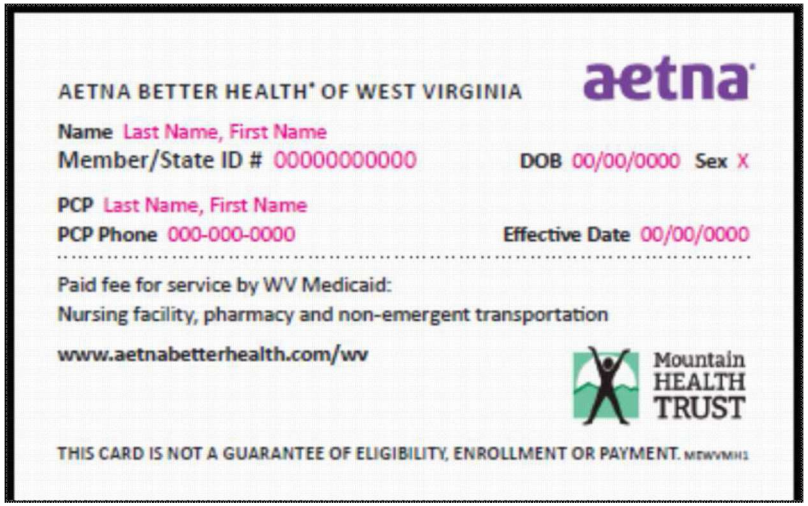
- Aetna Special Investigation Unit (SIU)
  - Monitoring of fraudulent billing practices
  - Verification of services
  - Documentation review
- To report suspected fraud, waste or abuse
  - Call 1-844-405-2016
  - Use the Fraud, Waste & Abuse Reporting Form on www.aetnabetterhealth.com/westvirginia
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

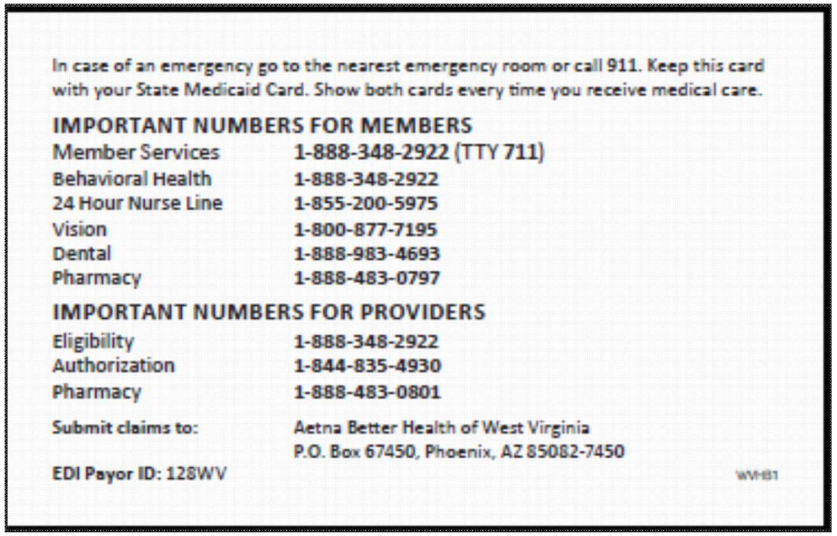
- ***Appointment Accessibility Standards***
  - ***PCPs***
    - Regular/Routine PCP (non-urgent) – within 21 calendar days
    - Urgent Care (care for a minor health problem) – within 48 hours
    - Emergency Care (life threatening or severe problem) – Immediately or referred to ER facility
    - General 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

- ***PCP Roles and Responsibilities***
  - Manage and coordinate the overall health care of members
  - Provider behavioral health services within the scope of their practice
  - Make appropriate referrals to participating practitioners or providers (including behavioral health)
  - Obtain prior authorization for any referrals to non-participating practitioners or providers
  - Provide or arranging for on-call coverage 24 hours/day, 7 days/week
  - Accept new members unless we have been provided with written notice of a closed panel
  - Facilitate adherence to the EPSDT Periodicity Schedule
  - Maintain comprehensive and legible medical records
  - Follow MCO-established procedures for coordination of in-network and out-of-network services for Medicaid enrollees

Member ID Cards

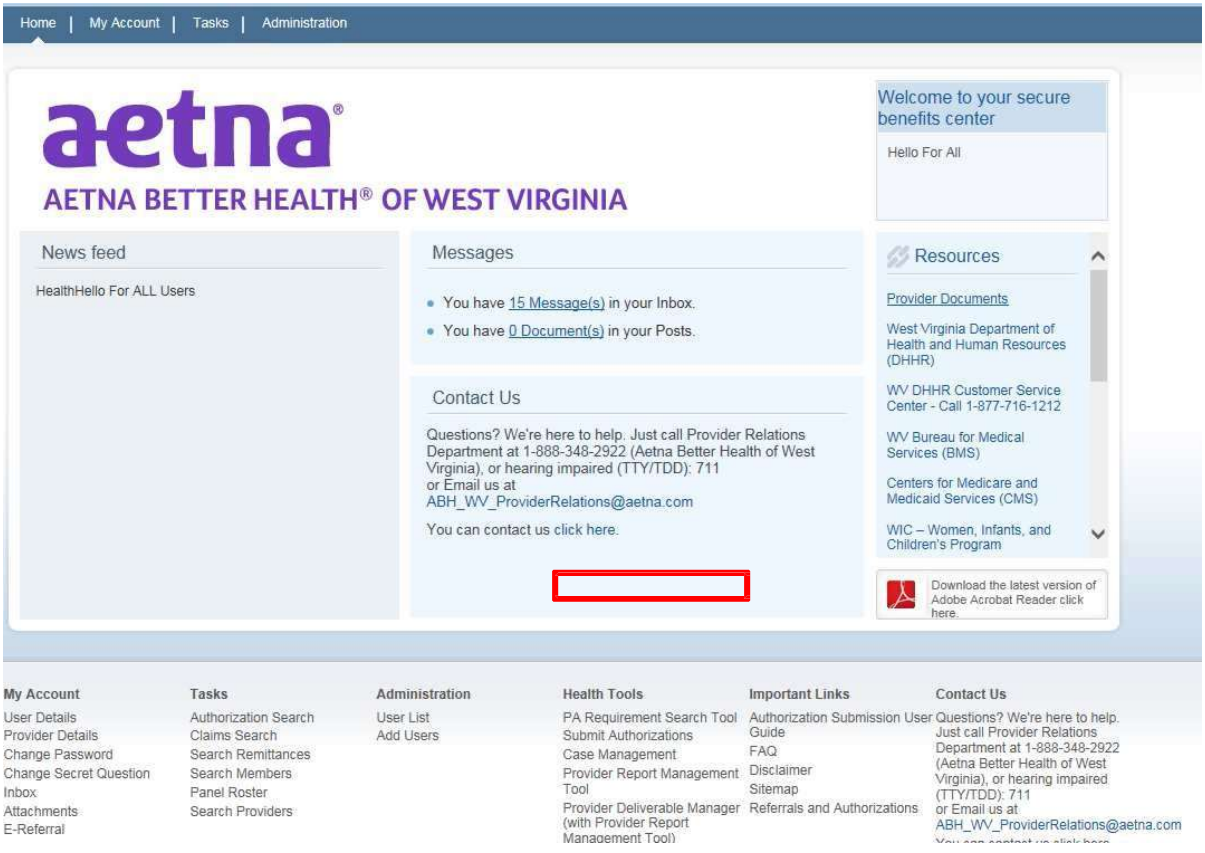






PRIORAUTHORIZATION

- You can request Prior Authorizations
  - Call 1-844-835-4930
  - Fax attached Prior Authorization Form to 1-866-366-7008
- *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
- Prior Authorization Requirement Search Tool (ProPAT) - Provider Portal View



- Once you get to ProPAT (see below), you can put your CPT or HCPC codes into the search fields and see if the service(s) you provide requires Prior Authorization (PAR Providers)

General Information/Code Search:

- The term Prior Authorization (PA) is the utilization review process used to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage.
- Benefit exceptions will require a PA. Benefit limits are based on the member's calendar year.
- The five character codes included in the Aetna Medicaid PA Requirement Search Tool are obtained from Current Procedural Terminology (CPT), copyright 2010 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures performed by physicians.
- **The ProPAT authorization tool is NOT "place of service" specific.**
- If you have any questions about authorization requirements or need help with the Aetna Medicaid PA Requirement Search Tool, contact Aetna Better Health of West Virginia Provider Relations at 1-888-388-1744.
- PA requirement results are valid as of today's date only. Future changes to CPT or Healthcare Common Procedure Coding System (HCPCS) codes that require PA will be communicated by Aetna Better Health on the home page of Aetna Better Health's secure web portal.
- Benefit coverage may vary by member or may be subject to special conditions. Click here to be taken to the Aetna Better Health of West Virginia site or call your provider services representative at 1-888-388-1744.
- Search results are not a guarantee of claim payment.
- Sterilization – A signed consent form must be completed thirty (30) days prior to procedure but not more than 180 days prior, and the member must be more than twenty-one (21) years old. The form must be submitted with the claim; no PA is required.
- For Adult Dental (age 21 and over) benefits are limited to emergent services:
  - Removal of an abscessed tooth
  - Removal of a tumor or treatment of a fracture
  - Treatment of infection
- For **Advanced Radiologic Services** (CT, MR, PET) and pre authorizations please contact eviCore, Inc. (formerly MSI). Phone 1-888-693-3211. Fax completed authorization form and medical records to 844-822-3862 or 844-82AETNA.
- For **Pain Management** pre authorizations please contact eviCore, Inc. (formerly Triad). Phone 1-888-693-3211. Fax completed authorization form and medical records to 844-822-3862 or 844-82AETNA.
- **For Dental Prior Authorizations (less than age 21) call Scion Dental:** 855-844-0623
- **For Vision Prior Authorizations call Vision Service Plan (VSP):** 800-877-7195
- **Pharmacy benefits are carved out to the state.** For Pharmacy Prior Authorization contact **Rational Drug Therapy** by phone 800-847-3859 or fax 800-531-7787.

Additional Services Requiring Prior Authorization:

- All laboratory services related to genetic testing, regardless of place of service, require PA.
- All inpatient stays require PA.
- Behavioral Health services for Intensive Outpatient, Partial Hospitalization, Psychiatric Residential Treatment Facility, and Inpatient levels of care require PA. Some outpatient services also require authorization.
- Usually ALL services provided by non-participating providers require PA except the Professional Component (i.e.: RADIOLOGY, PATHOLOGY, ANESTHESIOLOGY, and LABORATORY) of Facility Based services, Urgent Care Services, and Emergency Ambulance Service.

Enter CPT or HCPCS Code(s) | OR | Select CPT Group: | ☐ Include only CPT or HCPCS codes where PA is required?

NOTE: When selecting by CPT group, the results displayed include CPT codes where PA requirements are both Yes and No, as specified on the PA List. To reduce the list of CPT or HCPCS codes to only those requiring PA, please check the box labelled "Include only CPT or HCPCS codes where PA is required?".

Search | Clear | Export

- Here is an example of codes that were looked up in the tool ProPAT

Enter CPT or HCPCS Code(s): E0251, A4335, A4367, G0333, 99213, 99214

OR Select CPT Group: ☐ Include only CPT or HCPCS codes where PA is required?

NOTE: When selecting by CPT group, the results displayed include CPT codes where PA requirements are both Yes and No, as specified on the PA List. To reduce the list of CPT or HCPCS codes to only those requiring PA, please check the box labelled "Include only CPT or HCPCS codes where PA is required?".

Search | Clear | Export

CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc Partner Detail
E0251	HOSP BED FIX HT W/ANY TYPE SIDE RAIL W/O MATTRSS	HCPCS - DME	NON-COV		
A4335	INCONTINENCE SUPPLY; MISCELLANEOUS	HCPCS - MED-SURG SUPPLIES	NO		
A4367	OSTOMY BELT EACH	HCPCS - MED-SURG SUPPLIES	NO		
G0333	PHARM DISPEN FEE INHAL RX; INITIAL 30-DAY SUPPLY	HCPCS - PROC/PROF SERVICES (TE	NON-COV		
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	E & M - OTHER E/M SERVICES	NO		
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	E & M - OTHER E/M SERVICES	NO		

- 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 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.

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

Prior Authorization Form

Fax to**: 1-866-366-7008** Telephone: **1-844-835-4930**

A determination will be communicated to the requesting provider.

- Incomplete requests will delay the prior authorization process.
- Please include pertinent chart notes to expedite this request.

TYPE OF REQUEST

URGENT (When a 7-calendar day non-urgent prior authorization could seriously jeopardize; the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or that a delay in treatment would subject the member to sever pain that could not be adequately managed without the are/service requested.)

NON-URGENT (for routine services – response within 7 calendar days)

INPATIENT

OUTPATIENT

HOME HEALTH CARE

PATIENT INFORMATION

Patient Name: Last First MI				**Date of Birth:** / /
I.D.#:			**Gender:** M F	**EPSDT special service request?**
Other Insurance? YES NO	**Name of Carrier**	**Job Related?** YES NO	**MVA?** YES NO	**Is the member currently pregnant?** YES NO

FROM- REQUESTING PROVIDER

Requesting Provider (Please Print):			**Tax ID#:**
Contact Person in Requesting Provider's Office:	**Telephone:** ( ) -	**Fax:** ( ) -	**WV Medicaid Provider #:**
Clinical Contact Person: **Phone: ( ) -**		**Name of PCP:**	

TO- WHERE WILL PATIENT RECEIVE SERVICES?

Physician/Provider/Facility Requested:	**Address:**	**Telephone:** ( ) -	**Fax:** ( ) -
Where services will be rendered? (Provide name of facility, if other than provider office or patient's home)			**WV Medicaid Provider #:**
Today's Date: / /		**Tentative Date of Service/Admission:** / /	
Were member school based services interrupted? **YES NO**		**Start Date:** / / **End Date:** / /	

CLINICAL INFORMATION

ICD- 10 Codes: (required) 1 2 3 4 5 6 7 8	**ICD- 10 Description:**
CPT/HCPCS CODES: (required) 1 2 3 4 5 6 7 8	**CPT/HCPCS Description:**
Comments (list # Days/Visits/Units or if services are needed at discharge): ***DME, Therapies and Infusions must have Rx attached. ***	

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:
To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.

CAREMANAGEMENT

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 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.

EVICORE – Prior Authorization

- Prior authorizations for MRI, PET, CT and Interventional Pain Management through EVICORE. EVICORE manages these type of imaging services.
- Authorization can be requested via phone, fax or web portal:
  - Phone 1-888-693-3211
  - Fax 1-888-693-3210
  - Web: https://myportal.medsolutions.com

CLAIMS

- 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 67450
    Phoenix, AZ 85082-7450
- 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 67450
      Phoenix, AZ 85082-7450
  - **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 the Provider Portal OR** by submitting on paper with the Dispute Form provided to:
      Aetna Better Health® of West Virginia
      ATTN: Claims Department
      P.O. Box 67450
      Phoenix, AZ 85082-7450
  - ***DO NOT SEND CORRECTED OR RESUBMITTED CLAIMS TO LOCAL HEALTH PLAN OFFICE. MUST BE SENT TO THE ABOVE ADDRESS OR IT WILL BE RETURNED TO SUBMITTER.***

- 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 PAR 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

- Non-PAR providers have no appeal rights
- 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: Provider Appeals
    500 Virginia Street, East, Suite 400
    Charleston, WV 25301
- Decision response is within thirty (30) calendar days
- The Appeal decision is the final decision. There are no 2nd level appeals

Aetna Better Health of WV, Inc.

Provider Resubmission, Dispute 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 or dispute claims and 90 days to appeal claims.**

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 24 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®
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: RESUBMITTED CLAIMS
PO Box 67450
PHOENIX, AZ 85082-7450

OR: We have a GREAT new option to submit your *Requests for Reconsideration ONLY (NOT CORRECTED CLAIMS)* with supporting documentation through our Provider Web Portal. Attached is the Online Claim Resubmission Guide on how to submit your Requests for Reconsideration.

A **Dispute** is defined as an expression of dissatisfaction with any administrative function including policies and decisions based on contractual provisions inclusive of claim disputes. Provider Disputes do not include pre-service disputes that were denied due to not meeting medical necessity. **Practitioners and providers have 120 days from the initial remittance date to dispute claims.**

CLAIM DISPUTES:

- Submit the completed *Provider Resubmission and Dispute form*, found attached, or other document clearly marked "CLAIM DISPUTE" within 120 days of the remittance date.
- Can be an individual claim or a group of claims with the same issue

Examples of a claim dispute:
Disputing a claim payment or denial based on a fee schedule or contractual issue
Disputing a claim payment or denial based on a coding issue

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.

Other Disputes (Participating providers only)

- Any aspect of the administrative functions, policies, procedures.

ALL DISPUTES MUST BE SUBMITTED TO: Aetna Better Health of WV
ATTN: PROVIDER RELATIONS
500 Virginia Street, E, STE 400
Charleston, WV 25301

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. NON-PAR Providers do not have Appeal rights.

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
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 "FILING AN APPEAL" to:

Aetna Better Health of WV, Inc.
ATTN: Appeals & Grievance
500 Virginia St E Ste 400
Charleston, WV 25301

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.

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

Submissions with Attachments via our Provider 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:

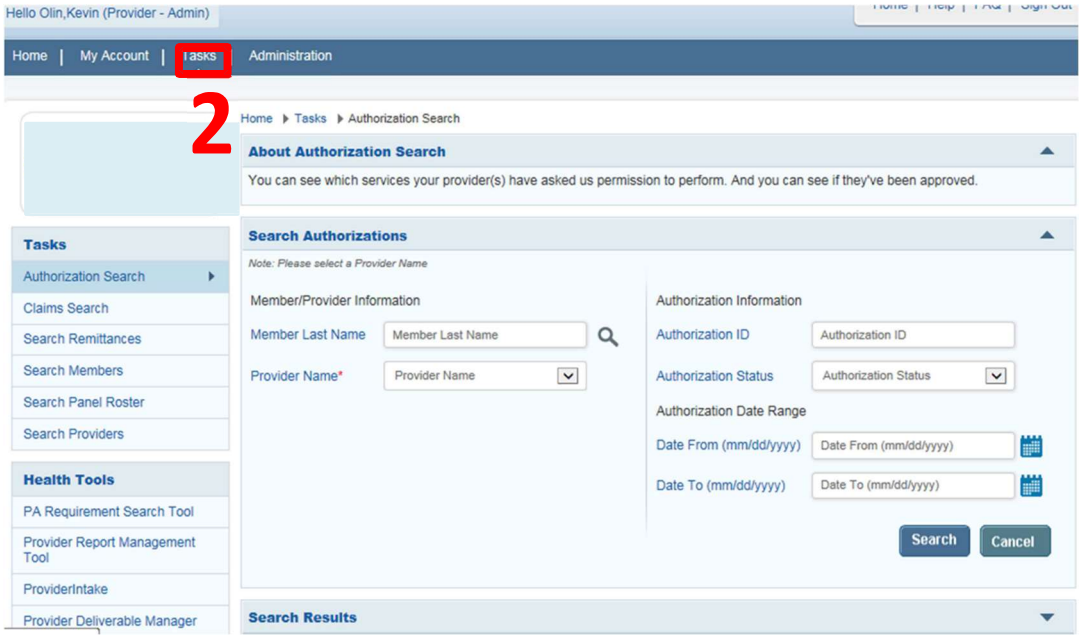
- **Corrected claims are not to be submitted through this process.** Corrected claims must be submitted as they are currently (electronically or through resubmission process. Paper resubmissions GO TO P.O. Box 67450, Phoenix, AZ 85082-7450). Examples of corrected claims include but are not limited to:
  - 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.

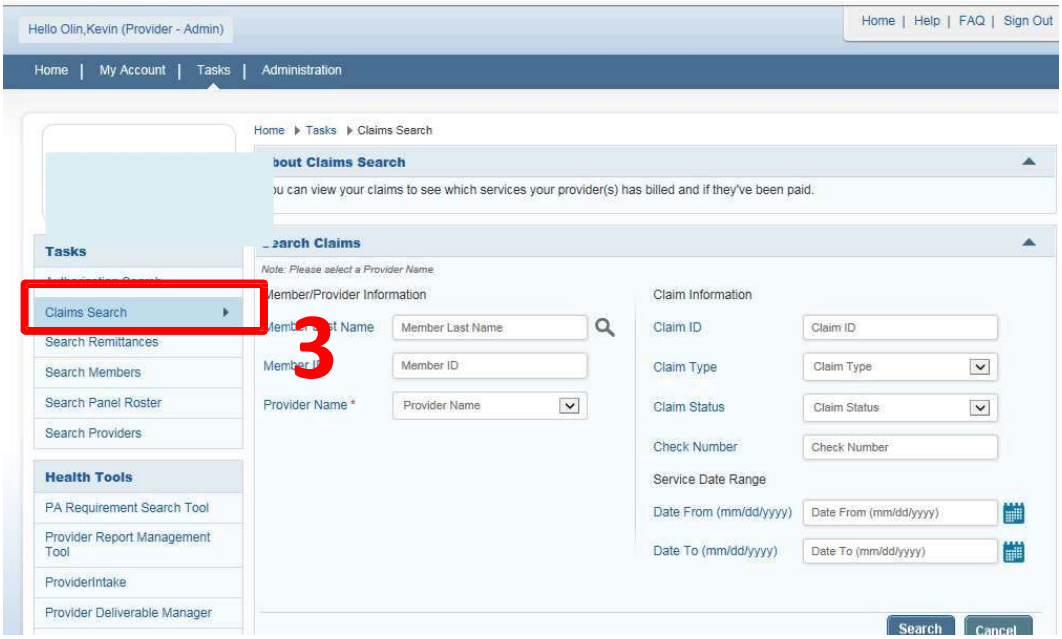
Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Claim resubmission forms from Secure Web Portal screen

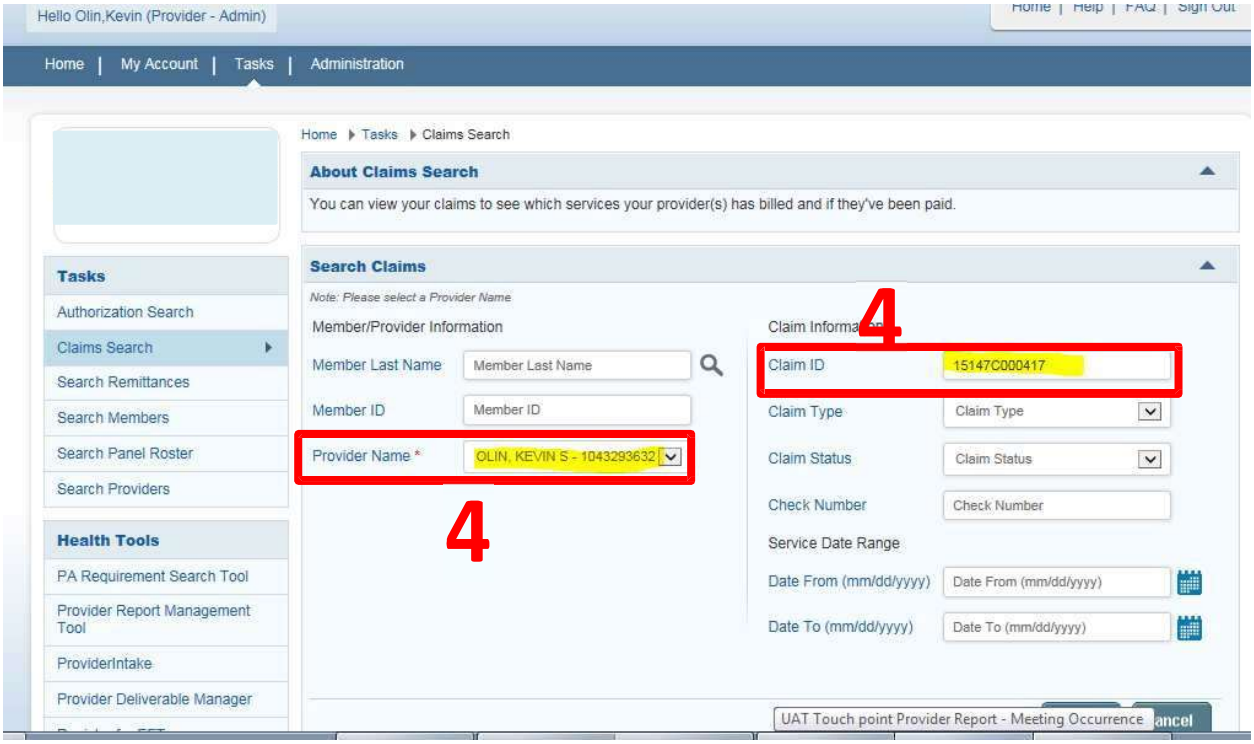
1. The Provider logs into the Aetna Better Health of WV Secure **Web Portal**.
2. Click on **Tasks** from the banner on the top



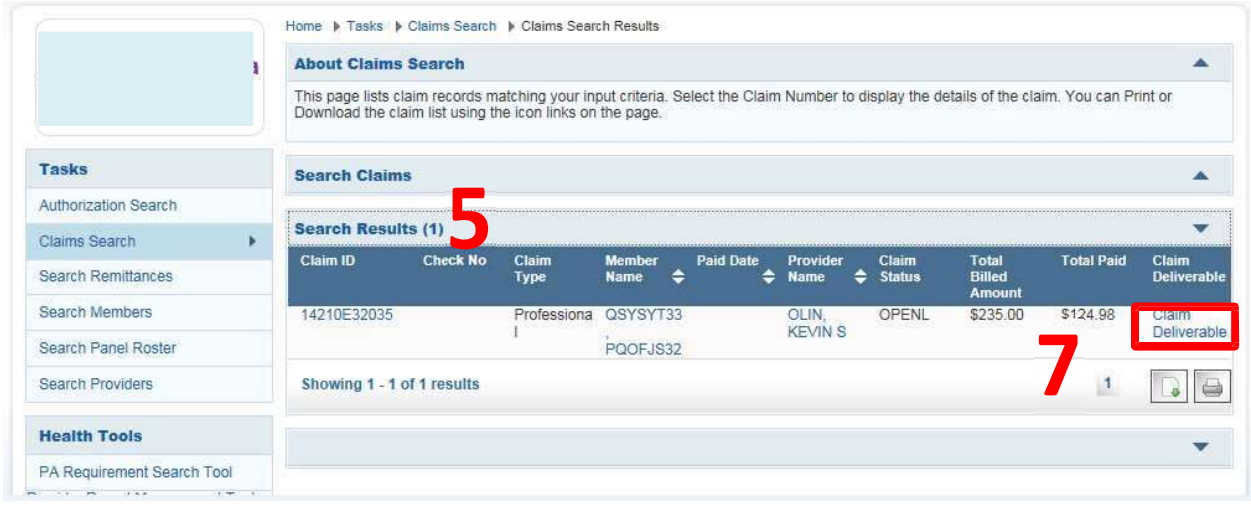
3. Click on **Claims Search** located in the left pane



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

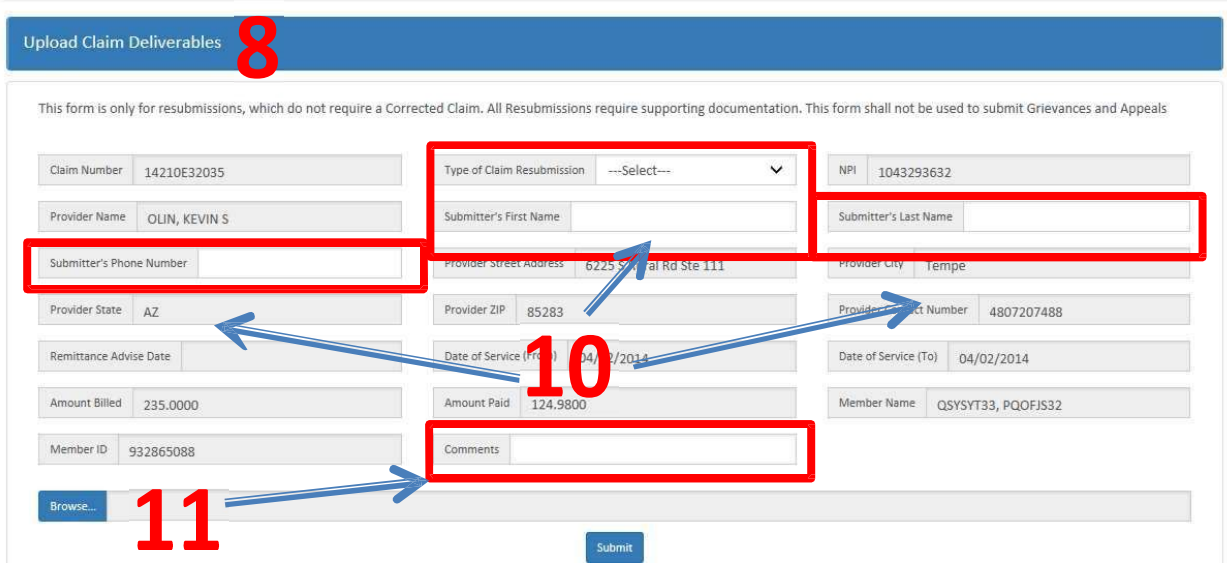


5. The Search results grid will load.
6. The Provider will see **Claim Deliverable** link under the **Claim Deliverable** column in the Search results grid.
7. Click on the **Claim Deliverable** link

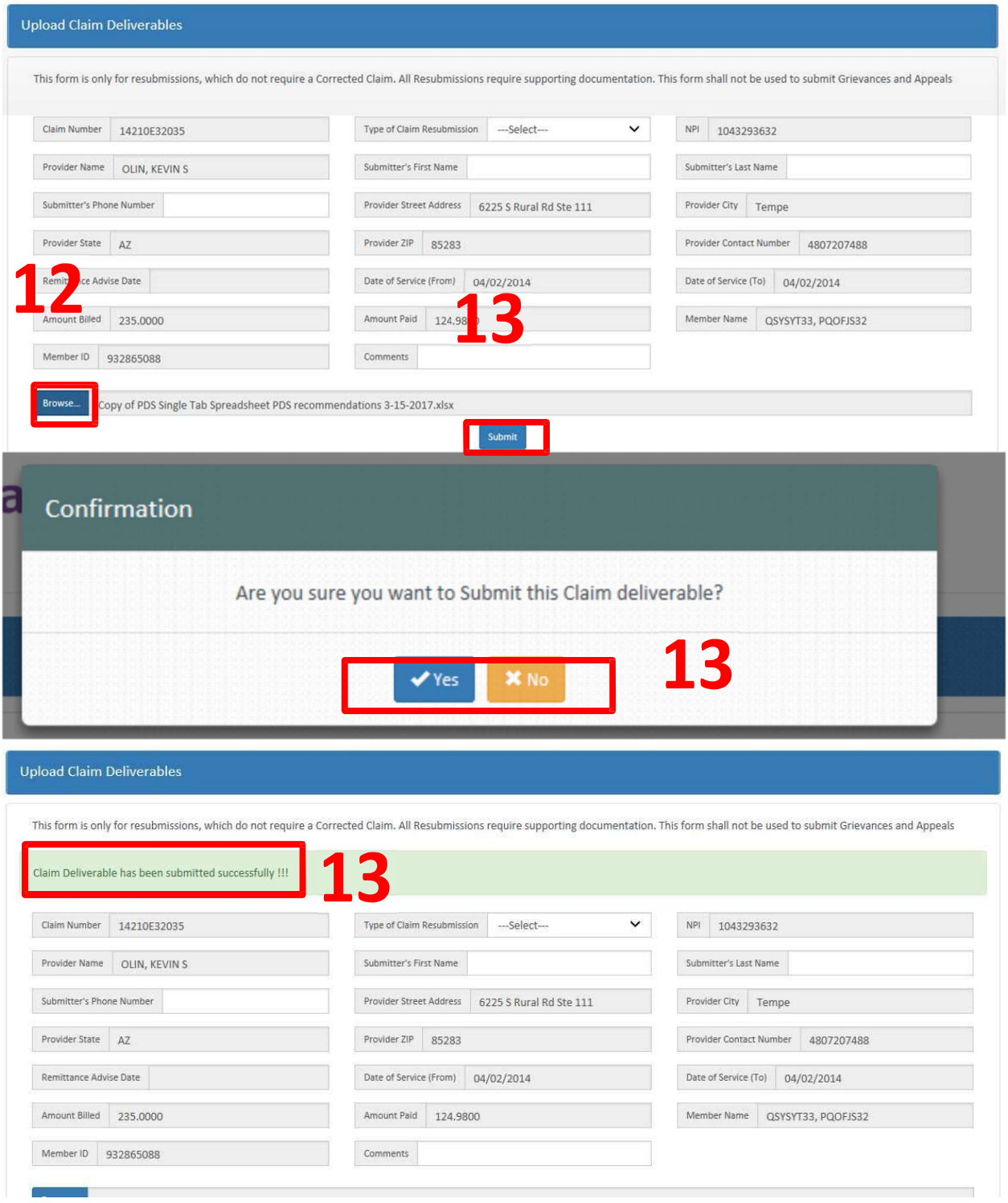


8. This will take the Provider to the **Upload Claim Deliverables** screen.
9. Most of the information on the screen will be 'Auto populated' based on the claim number.

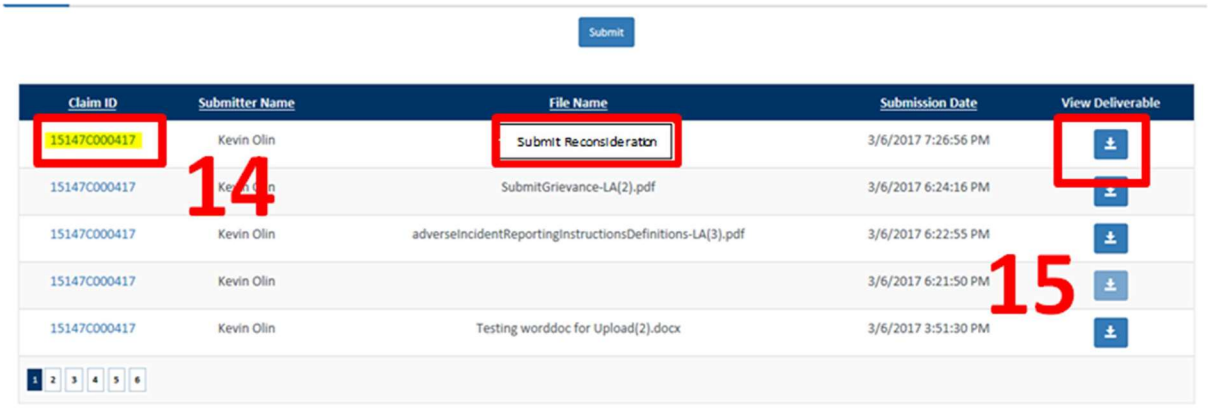
10. Provider will select a **Type of Claim Resubmission** from the dropdown and enters the information in the relevant **Mandatory fields Submitter's First Name, Submitter's Last Name, and Submitter's phone number** fields.
11. The **Comments** field is a mandatory input required, **when** the selected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



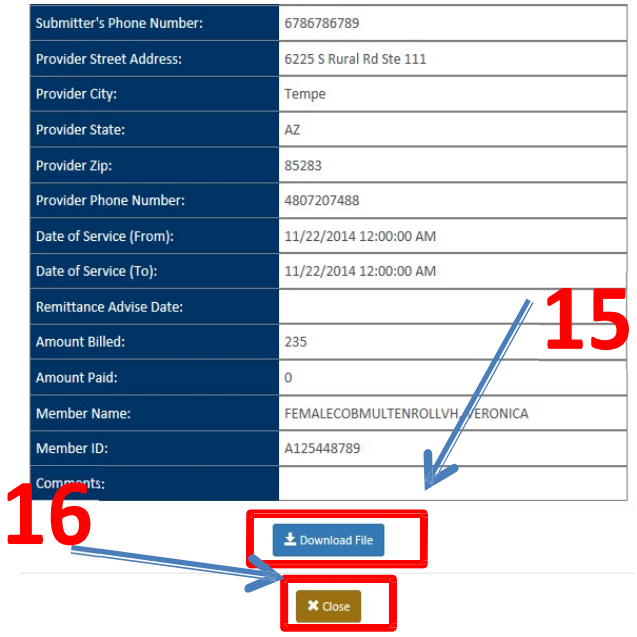
12. The Provider can upload supporting documentation (any type of file) from here through clicking the **Browse** button and thus activating the Browse functionality.
13. On successful attachment of the supporting documentation, the Provider clicks **Submit** and receives a **Confirmation message** window.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


Upload Claim Deliverables
This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals
Claim Number 14210E32035
Type of Claim Resubmission ---Select---
NPI 1043293632
Provider Name OLIN, KEVIN S
Submitter's First Name
Submitter's Last Name
Submitter's Phone Number
Provider Street Address 6225 S Rural Rd Ste 111
Provider City Tempe
Provider State AZ
Provider ZIP 85283
Provider Contact Number 4807207488
Remittance Advise Date
Date of Service (From) 04/02/2014
Date of Service (To) 04/02/2014
Amount Billed 235.0000
Amount Paid 124.9800
Member Name QSYSYT33, PQOFJS32
Member ID 932865088
Comments
12
13
Browse...
Copy of PDS Single Tab Spreadsheet PDS recommendations 3-15-2017.xlsx
Submit
Confirmation
Are you sure you want to Submit this Claim deliverable?
Yes
No
13
Upload Claim Deliverables
This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals
Claim Deliverable has been submitted successfully !!!
13
Claim Number 14210E32035
Type of Claim Resubmission ---Select---
NPI 1043293632
Provider Name OLIN, KEVIN S
Submitter's First Name
Submitter's Last Name
Submitter's Phone Number
Provider Street Address 6225 S Rural Rd Ste 111
Provider City Tempe
Provider State AZ
Provider ZIP 85283
Provider Contact Number 4807207488
Remittance Advise Date
Date of Service (From) 04/02/2014
Date of Service (To) 04/02/2014
Amount Billed 235.0000
Amount Paid 124.9800
Member Name QSYSYT33, PQOFJS32
Member ID 932865088
Comments

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®

HEDIS® 2020 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® 2020 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 department 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® 2020 = Calendar Year 2019 Data

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

- Tips and best practices
- Member Incentive Programs for 2020
- Describes various Measures for Children, Adults, Women, Chronic Conditions and Behavioral Health
- CAHPS Survey Information
- Physician Documentation Guidelines and correct billing codes