AETNA BETTER HEALTH® OF MISSOURI

Quick reference guide

Category	Key contact information
Member Services • Member Eligibility • PCP assignment changes • Interpreter requests	1-800-566-6444 Secure provider web portal: **http://aetnabetterhealth-missouri.aetna.com/**
State of Missouri eligibility verification	1-573-635-8908 **www.emomed.com** Note: Verify eligibility and health plan assignment with every date of service due to State of Missouri day specific eligibility
Claims Inquiry/Claims Research Department (CICR)	1-800-566-6444
Claim Submission Information	EDI Payor ID (Claim) : **128MO** P.O. Box 65855, Phoenix, AZ 85082-5855
Prior Authorizations	**1-800-566-6444** Options include: • CMPCN Member PA requests • Radiology (Med Solutions) • Pain Management (TRIAD) • Dental (DentaQuest) • Inpatient, delivery notif., initial therapy eval. • All other requests
Case and Disease Management referrals	1-800-566-6444
Complaints and Appeals	Aetna Better Health of Missouri—Appeals 10 S. Broadway Suite 1200, St Louis MO 63102 Fax: **1-844-692-5109**

Category	Key contact information
Dental (DentaQuest)	1-800-566-6444 **www.dentaquest.com**
Vision (MARCH vision)	1-888-493-4070 **www.marchvisioncare.com**
Transportation (MTM)	1-800-688-3752
Pharmacy (MO HealthNet)	1-800-392-8030
State of Missouri Medicaid Fraud Control Unit	1-800-286-3932
Reporting Fraud and Abuse	1- 800-566-6444
Provider Relations	1-800-566-6444 Fax: 1-866-278-9981 E-mail: **MissouriProviderRelations@aetna.com** Aetna Better Health of Missouri 10 S. Broadway, Suite 1200 St. Louis, MO 63102
EFT/ERA Set up	Complete the EFT or ERA form on **www.aetnabetterhealth.com/mo**
Website	**www.aetnabetterhealth.com/mo**
Secure Provider Portal and Login Page	**http://aetnabetterhealth-missouri.aetna.com/**

Claims

Claims & Resubmissions

Aetna Better Health of Missouri requires clean claims submissions for processing.

To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure

Participating providers are required to submit valid, current HIPAA compliant codes that most accurately identify the member's condition or service(s) rendered.

Timely Filing Requirement

- Initial Claims: 90 days from date of service or discharge
- Corrected Claims: 180 days from initial remit date

We process clean claims according to the following timeframes:

- 90% of clean claims adjudicated within 15 business days
- 99% of clean claims adjudicated within 30 business days
- Release all adjudicated/pended claims within 60 business days

Electronic Claims Submission

Aetna Better Health of Missouri

Emdeon Payor ID (837 Claim): 128MO

Participating providers should use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors.

Also, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.

- Emdeon is the EDI vendor we use.
- Providers need to contact the software vendor directly for further questions about their electronic billing.

All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Missouri policies and procedures.

Real Time Transaction information (EMDEON)

Use **ABHMO** to:

- Check eligibility (270/271)
- Check claim status (276/277)
- Check/submit an authorization (278)

Claim Inquires call 1-800-566-6444

To review the status of a claim, participating providers can:

- Visit Online Secure Provider Web Portal
- Call Claims Inquiry/Claims Research (CICR) at **1-800-566-6444**
- Review of remittance advice

Paper Claims Submissions and/or Resubmissions

For resubmissions, please stamp or write one of the following on the paper claims:

- Resubmission, Rebill, Corrected Bill, Corrected or Rebilling in black ink.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- Use the **Reconsideration Form** on our website.
- An updated copy of the claim. All lines must be re-billed. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to be denied as a duplicate. Please note: Providers will receive an EOB when their disputed claim has been processed.
- Contact Claims Inquiry Claim Research **1-800-566-6444** during regular office hours to discuss claim disputes and re-submissions.
- Providers can review our Secure Provider Web Portal to check the status of a resubmitted/reprocessed and or adjusted claim. These claims will be noted as "Paid" in the portal.
- View our portal at **ww.aetnabetterhealth.com/mo.** Click on the portal tab under the provider page.

Prior Authorizations

How to request Prior Authorizations

To submit a prior authorization request, you can:

- Call our toll-free number at **1-800-566-6444, option 5**
- Submit through our 24/7 Secure Provider Web Portal **http://aetnabetterhealth-missouri.aetna.com/**
- Fax the request form to **1-866-341-1327** (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing

To check the status of a prior authorization a provider submitted or to confirm that we received the request, just login to our Secure Provider Web Portal at **http://aetnabetterhealth-missouri.aetna.com/**or call us at **1-800-566-6444**. The portal will allow you to check status, view history, and or email a Case Manager for further clarification if needed.

You can find more information about our Secure Provider Web Portal in the Provider Manual. If response for non-emergency prior authorization is not received within 2 business days, please contact us at **1-800-566-6444**.

Requesting Prior Authorization

When requesting prior authorization, please include:

- Member's name and Date of Birth
- Member's identification number (MO HealthNet ID#)
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service

Emergency services do not require prior authorization; however, notification is required the same day. For post stabilization services, hospitals may request prior authorization by calling **1-800-566-6444**

All out of network services must be authorized.

Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

Decision	Decision/notification timeframe
Urgent pre-service approval	Initial determination within 24 hours from original request
Urgent pre-service denial	Initial determination within 24 hours from original request
Non-urgent pre-service approval	Initial determination within 36 hours inclusive of one business day from original request
Non-urgent pre-service denial	Initial determination within 36 hours inclusive of one business day from original request
Urgent concurrent approval	Determination is made within 1 business day of obtaining all necessary information to make determination
Urgent concurrent denial	Determination is made within 1 business day of obtaining all necessary information to make determination
Post-service denial	Determination made within 30 working days of receiving all necessary information
Termination, suspension reduction of prior authorization	At least 10 calendar days before the date of action

Tools and Resources

Public Website

- Link to Secure Web Portal
- Online Provider Search Tool
- Clinical Practice Guidelines
- Provider Education
- Provider Manual
- Member Handbook
- Forms
- Tools & Resources

Visit **www.aetnabetterhealth.com/mo**

Secure Web Portal (24/7) - Functionality

- Verify member eligibility & PCP assignment
- Download various forms used to submit authorization requests
- Submit and verify prior authorization requests
- Review prior authorization requirement search tool
- Check claims status
- Review PCP roster of assigned members

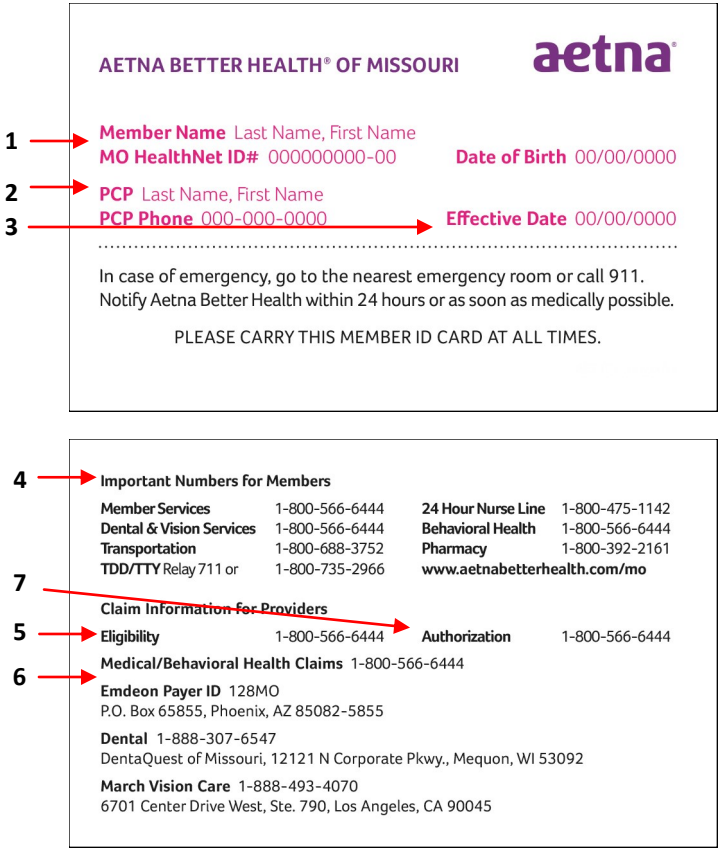
Go to **http://aetnabetterhealth-missouri.aetna.com/**

Secure Web Portal Registration & Login

- Designate a group administrator for your tax id number and complete a portal registration form
- Send completed registration form to Provider Relations by fax or email
- Confirmation email issued to account administrator with login instructions
- Registration form available on public website

Login at **http://aetnabetterhealth-missouri.aetna.com/**

Member ID card



1. **Member name and ID#**
2. **PCP name and phone number**
3. **Member's effective date with plan**
4. **Important numbers for members**
5. **Eligibility verification**
6. **Claim information for providers**
7. **Authorization number**
8. **CMPCN member 24 Hour Nurse Line**
9. **CMPCN Prior authorization number**
10. **CMPCN logo**

Children's Mercy Pediatric Network (CMPCN) ID card