Aetna Better Health® of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

Provider claim reconsideration, member appeal and provider complaint/grievance instructions

Provider submissions will be reviewed and processed according to the definitions in this document, including but not limited to resubmissions (corrected claims), retroactive authorization requests, appeals, complaints and grievances. Provider claim reconsiderations and retrospective authorization reviews do not include pre-service disputes that were denied due to not meeting medical necessity. **Pre-service denials are processed as member appeals and are subject to member policies and timeframes.**

Timeframe to request each option

Options/pages	Provider submission timeframe
Resubmission – corrected claim, page 2	Within 180 days of the date of service
Claim reconsideration – pages 2-3	Within 90 days of original denial
Retroactive authorization request (post-service) – page 4	**Existing timeframe**: Dispute must be requested within thirty (30) calendar days from the date of service. **Effective 12/1/22:** Dispute must be requested within sixty (60) calendar days from the date of denial.
Member appeal (provider submitting on member's behalf) – page 5	Within 60 days of the original denial
Provider complaint/grievance – pages 5-6	At any time
State complaint portal – page 6	• Over 30 calendar days from and under 60 calendar days post receipt of MCO tracking number Untimely response to appeal or complaint beginning day 31 • Within 30 calendar days after appeal decision or complaint • Not to exceed 60 calendar days from submission of the appeal or complaint

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Corrected claim

A **corrected claim** is a request for review of a claim denied due to incorrect coding or missing information that prevents Aetna Better Health® of Illinois from processing the claim. The claim with the missing information may be resubmitted electronically or in hard copy.

Examples of a corrected claim: (Step 1 if applicable)
Newly added modifier
Code changes
Any change to the original claim

Here are the ways to resubmit a claim:

Electronic – Clearinghouse: Resubmit your claim via your Clearinghouse to payer ID 68024. When submitting claims to our plan, use the payer ID number "68024". For CMS-1500 claims you'll need to identify your resubmission with a "7" indicator field and TOB XX7 for UB-04 claims.
Electronic – Portal: Claims can also be resubmitted electronically via the WebConnect portal. When submitting claims to our plan, use the payer ID number "68024". For CMS-1500 claims you'll need to identify your resubmission with a "7" indicator field and TOB XX7 for UB-04 claims.
Paper: Submit a corrected claim marked at the top of the claim **"CORRECTED CLAIM FOR RESUBMISSION"** For CMS-1500 claims you'll need to identify your resubmission with a "7" indicator field and original claim number in box 22 and TOB XX7 for UB-04 claims, reference original claim number in box 64.

- For an updated claim, all lines must be rebilled with any additional appropriate documentation. Corrected claim can be mailed to:

Aetna Better Health of Illinois
P.O. Box 982970
El Paso, TX 79998-2970

Reconsideration

A **claim reconsideration** can be submitted if a claim does not require any changes, but a provider is not satisfied with the claim disposition and wishes to dispute the original outcome.

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Examples of reconsiderations: (Step 1, if applicable)
Itemized bill • 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.)
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
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 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
Coordination of benefits • Attach EOB or letter from primary carrier
Claim/coding edit • We use two (2) claims edit applications: Claim Check and Cotiviti. Please refer to the Provider Manual for details.

- Submit additional information required to reconsider the claim. Information should be submitted single-sided.
- Please refer to the provider manual for provider filing timeframes.

Claim reconsiderations should be submitted to:

Aetna Better Health of Illinois
P.O. Box 982970
El Paso, TX 79998-2970

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Retrospective authorization dispute

A **retrospective authorization dispute** is a request for review of post-service, authorization-related claim denials for potential reprocessing when they are:

1) attributed to authorizations not kept current due to extenuating circumstances, **or**
2) medical necessity disputes requiring review of medical records.

Examples of retrospective authorization disputes: (Step 2, if applicable)
Requests by provider for review of claims for medical necessity
Dispute of denied days during concurrent review
Request for review of additional services not authorized
Retro authorization request • Claims that were denied due to no authorization on file. Medical records must be included with the resubmission.

Submit your request by fax or mail with all supporting documentation clearly marked as **"FILING A RETROSPECTIVE AUTHORIZATION DISPUTE**" to:

Aetna Better Health of Illinois
Attn: Appeal and Grievance Department
P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181
Fax: **844-951-2143**

Retro authorization requests can also be submitted electronically, again marked as **"FILING A RETROSPECTIVE AUTHORIZATION DISPUTE**" to:

Email: **ILAppeal and Grievance@AETNA.com**
Provider Portal: Use Provider Appeal option with the heading bolded above

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Appeal

An **appeal** can be submitted on behalf of the member for review of the following items. Please refer to the Aetna Better Health of Illinois Provider Manual, located on our website at **AetnaBetterHealth.com/Illinois-Medicaid** for details.

Examples of appeals: (Step 2 if applicable)
On behalf of a member: • Continued stay concurrent review • Urgent or Emergent review • 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

Provider complaint/grievance

A **provider complaint/grievance** is an expression of dissatisfaction unrelated to a request for us to reconsider our decision on the denial of a claim or the payment on a claim. This is also referred to as a grievance. Please refer to the Provider Manual on our website at **AetnaBetterHealth.com/Illinois-Medicaid** for details.

Examples of complaints/grievances: (Step 1, if applicable)
Dissatisfaction with administrative functions or policies
Vendor staff service or behavior
Aetna staff behavior
On behalf of a member • When filing on behalf of a member the request is processed as a **Member Grievance** andis subject to the member grievance policies and timeframes

If any of the above member appeal or provider complaints/grievance examples apply, please do not use the Resubmission & Reconsideration Form. You may submit your request to file a member appeal or a provider complaint/grievance to the address below.

Please submit your request by fax or mail with all supporting documentation clearly marked as **"FILING AN APPEAL PROVIDER COMPLAINT"** or **"FILING A GRIEVANCE**" to:

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3200 Highland Avenue, MC F648
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Aetna Better Health of Illinois
Attn: Appeal and Grievance Department
P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181
Fax: **844-951-2143**
Email: **ILAppealandGrievance@AETNA.com**

You may also submit a provider complaint/grievance through the portal. For all appeals and grievances submitted you can log into the portal within 5 business days to check the status of your request and obtain a unique identifier for the item submitted.

State portal complaints

Following the claim reconsideration process, you may make a complaint through the Illinois Department of Healthcare and Family Services (HFS) through the state portal.

When attempting to resolve issues with Aetna Better Health of Illinois, you will receive a unique reference number. The reference number will vary based on how you attempted to resolve the issue.

- When contacting Customer Service at **1-866-329-4701**, providers will receive a tracking/reference number from the agent handling your inquiry (i.e., #PDXGR1234567).
- When contacting network relations consultants, they will provide a reference number (i.e., #1234).
- When mailing in or submitting a claim reconsideration through our Provider Portal, the provider must complete the Claim Reconsideration form and attach or upload any appropriate supporting documentation. When submitting a Claim Reconsideration, the portal will return a Claim Reconsideration confirmation number in the following format T######A###F#. The decision will be sent in the form of a provider remittance and the adjusted claims number from that remittance (i.e., the claim number ending in A1, A2, A3, etc.).

When filing a provider complaint or grievance you will receive a provider complaint or grievance number in the acknowledgment and resolution letters. (APXXXX or GRXXXX)

To submit through the portal; follow the directions at
https://medicaid.aetna.com/MWP/login