IL LTSS and Wavier Services Provider Overview

2026

Aetna Medicare FIDE (HMO D-SNP) Overview for Waiver Providers

TOPICS:

- Member Enrollment & Eligibility
- Provider Roles & Responsibilities
- Claims, Billing & Authorizations
- Secure Provider Portal
- Provider Resources

Member Enrollment & Eligibility

Enrollment Qualifications & Service Area

Aetna Medicare FIDE (HMO D-SNP) Provides benefits to permanent residents of Illinois. Enrollees must be 21 and over who qualify for both Medicare and Medicaid under the Illinois Department of Health and Family Services (IL HFS).

ID Cards & Enrollment

Verifying Member Eligibility:
You can verify member eligibility, PCP assignment, and benefits by:

- Using the State **IMPACT Home**
- Using the **Availity Provider Portal**

Members have only one ID card for Medicare and Medicaid. You will only submit claims directly to Aetna Better Health. Do not submit claims directly to Medicare or Medicaid.

Provider Roles & Responsibilities

Provider Roles & Responsibilities

- Aetna Medicare FIDE (HMO D-SNP) participating providers are contractually obligated to comply with all guidelines and laws outlined in their Illinois FIDE Contract and their Provider Manual.
- The quality of our network and the ability to provide excellent service is dependent on having accurate provider data. Please update us if you have any change of address, telephone number, or other demographic information as soon as possible.

Claims, Billing, & Authorizations

Understanding Authorizations

- **Personal Care Services**: A Care Manager will reach out to you directly to provide authorization for a member needing personal care services. Authorizations for personal care services generally last for 6 months.

- **Chore Services:** We will send an email or fax to providers to bid on chore services. Responses are required within 14 days. If your bid is approved, an authorization for chore services will be issued. These authorizations generally last for 12 months.

- **Home Modifications:** We will send an email or fax to providers to bid on home modifications. Responses are required within 14 days. Authorizations are approved for 3 months, but work is expected to be completed as soon as possible (weather permitting and member agreeable).

Should a member require additional services, and an authorization is nearing its end date, please reach out to the assigned care manager for additional authorization. Please note that authorization dates can not overlap.

Waiver services are only paid if there is a current authorization in place in the name of the rendering provider. If you have general questions or are unable to reach a care manager directly, you may contact the Illinois Care Management through **email** or by fax at **1-866-586-6075**

Claims Submission

Aetna Medicare HIDE (HMO D-SNP) members should NOT be balanced billed for any covered benefit.

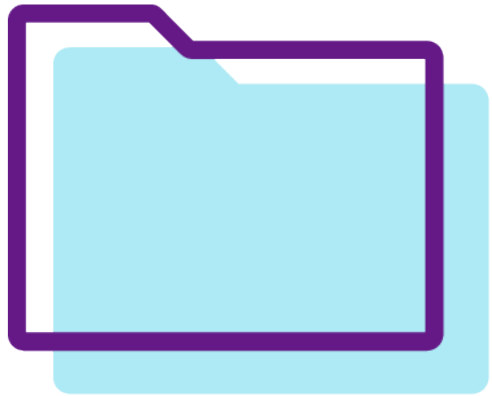
We have an automated system for processing claims for members enrolled in Aetna Medicare FIDE (HMO D-SNP)

- Using the member's ID number from the plan ID card, you'll only need to submit **one claim**. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits.
- You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to resubmit a secondary claim to Aetna.
- We encourage participating providers to electronically submit claims through ECHO. Use submitter ID **#26337** when submitting claims Aetna Medicare FIDE (HMO D-SNP).

Claim Submission (continued)

Electronic claims can be submitted through three ways:

- Your own claim clearinghouse
  - Ensure that your clearinghouse is compatible with ECHO using the 837 file format.
  - Please use Submitter ID **#26337** when submitting electronic claims
- Availity
- Information on Availity can be found at the **Provider Portal Website**



Paper Claims

Please use Submitter ID **#26337** when submitting paper claims

Aetna Medicare FIDE (HMO D-SNP)

PO Box 982970

El Paso, TX 79998-2963

Tips for Submitting Claims

- Confirm member's eligibility before rendering services.
- To best ensure timely and accurate payment of your claim, submit a "clean claim"
- A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party
- It does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity
- Clean claims are processed according to the following timeframes:
  - 90% of clean EDI claims adjudicated within 30 days of receipt
  - 90% of clean paper claims adjudicated within 90 days of receipt
- If providers have an approved authorization for a claim, include the authorization number on all claim lines pertaining to the authorization.

Tips for Submitting Claims (continued)

- Bill only for the procedure codes and diagnosis codes that are included on your authorization. Do not submit an invoice, but please save them in case of a future audit.
- Include your authorization number in Box 23.
- Places of service that are acceptable are 12 (home) or 99 (other).

Please note, that members do not have a copayment and can not be balance billed. Should you have any questions about claims payment, you can reach out to Provider Services for assistance and clarification **1-866-600-2139**.

Timely Filing

In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:

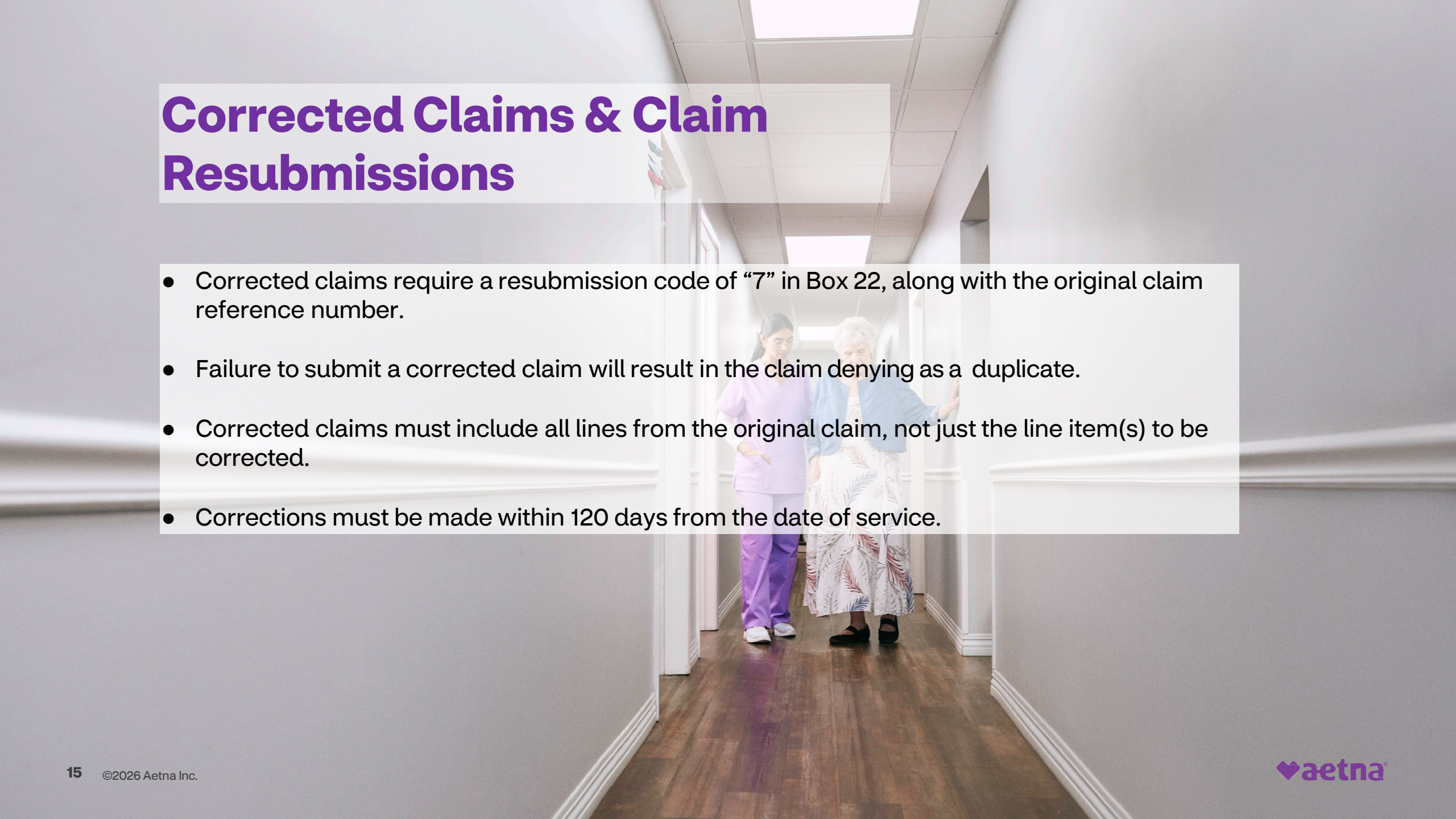
New claim submissions –

Claims must be filed on a valid claim form within 120 days from the date services were performed, unless there is a contractual exception.

Claim Resubmission –

Claim resubmissions must be filed within 180 days from the date of service. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may support a different outcome or decision.

Corrected Claims & Claim Resubmissions



- Corrected claims require a resubmission code of “7” in Box 22, along with the original claim reference number.
- Failure to submit a corrected claim will result in the claim denying as a duplicate.
- Corrected claims must include all lines from the original claim, not just the line item(s) to be corrected.
- Corrections must be made within 120 days from the date of service.

Provider Dispute and Provider Appeal Process

Participating Providers: Participating Providers can submit a provider dispute on behalf of the member. It is a request to review a denied service. Providers have 180 days from the date of determination, unless otherwise indicated in your provider agreement, to submit a claims resubmission/reconsideration, corrected claim or dispute.

Response Time?
Disputes average 30 business days. Disputes are reviewed by a third-party not involved in original decision. Please go through the dispute process first, before reaching out your assigned Provider Representative for assistance.

Non-Participating Providers: Non-Participating Providers can submit a Provider Appeal. It is a request to review a denied service. Providers can appeal our decisions through writing with documentation supporting they should receive different payment under the original Medicare within sixty-five (65) calendar days from the remittance date.

Provider Disputes

If you are a Contracted Provider, you may use the **Dispute Form** found online to have your claim reconsidered.

Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

Aetna Medicare FIDE (HMO D-SNP)

PO Box 982970

El Paso, TX 79998-2963

Incomplete or missing information may cause the decision to be upheld or returned to Provider. Common mistakes include:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed

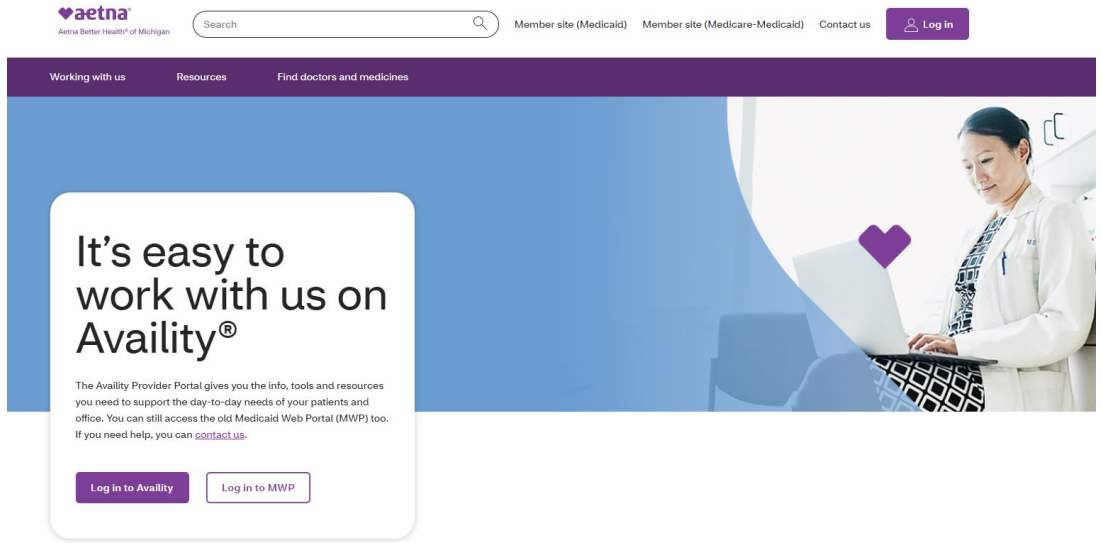
Availity Provider Portal

Provider Portal

If you are already registered in Availity, you will simply select **Aetna Better Health All Plans NJ-VA MAPD-SNP** for Aetna Medicare FIDE (HMO D-SNP) from your list of payers to begin accessing the portal and all of the features.

Find out more at the Aetna Medicare FIDE (HMO D-SNP) Provider Portal Website

If you are not registered, we recommend that you do so immediately by going to the above portal location.



Availity®

aetna®

Provider Resources

Provider Relations

Our provider Relations staff is available to you Monday - Friday 8 AM - 5 PM to assist you on any facets of your relationship with Aetna Medicare FIDE (HMO D-SNP).
You can reach Provider Relations via:

Phone Number: **1-866-600-2139**

Email: **COEProviderServices@AETNA.com**

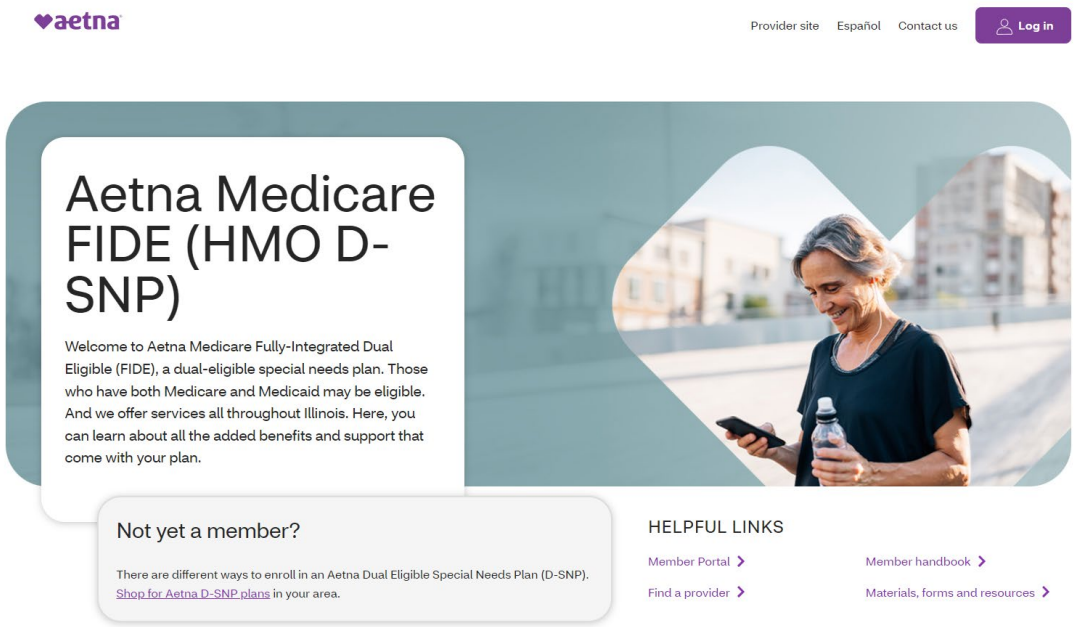
Each participating provider group is also assigned a Provider Relations Liaison who can assist with any escalated claim questions or other concerns.

Visit Our Website

Providers can access the Aetna Medicare FIDE (HMO D-SNP) Plan **website.** There you'll find tools and resources to make doing business with us quick and simple.

We've listed a few of the tools and resources found on the "For Providers" tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Document Library
- Provider Education



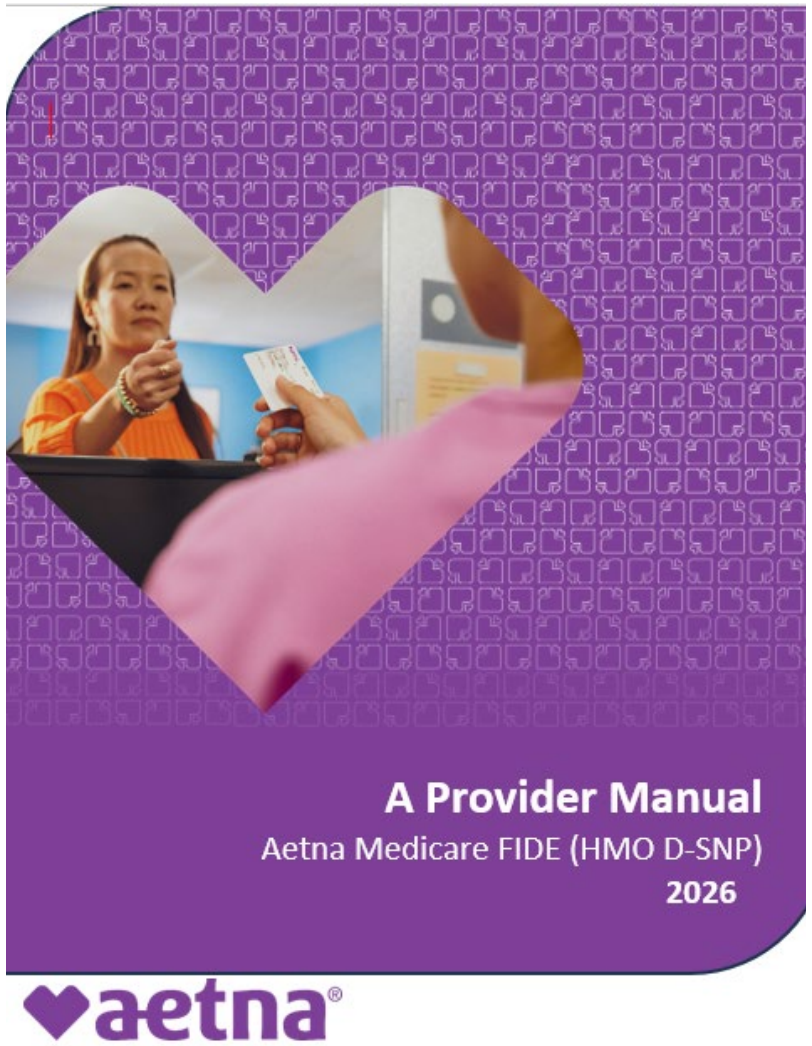
Provider Manual

The provider manual contains plan policies, procedures and benefits.

You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available on our **Provider Manual Page**.

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department at **1-866-600-2139** or by email at **COEProviderServices@AETNA.com**.



Additional Resources

Home and Community Based Services Waiver Programs

Billing and Reimbursement

IMPACT Registration

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