Aetna Better Health of Illinois HCBS Waiver Training

Introduction to our Provider Relations Leadership

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Agenda

- Home & Community-Based Services (HCBS) Waivers
- Determination of Need (DON) Assessment
- Prior Authorization Requirements
- Registration & Billing Reminders
- Commonly Billed Services
- Provider Types & Categories of Service
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- Transportation & Home Modification Billing
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- Change HealthCare Billing Overview
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- Mandatory Revalidation
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- Aetna Medicare FIDE/HMO D-SNP Clarification

Home and Community Based Waivers (HCBS)

Home and Community Based Waivers (HCBS)

Aetna Better Health of Illinois administers Home and Community-Based Services (HCBS) waivers for our members. These services help individuals remain in their homes and communities, supporting independent living and reducing the need for nursing home care. Aetna Better Health of Illinois oversees the management of the following HCBS waivers:

- **Persons who are Elderly Waiver: For individuals 60 years and older who live in the community.**
- **Persons with Disabilities Waiver: For individuals who have a physical disability.**
- **Persons with HIV or AIDS Waiver: For individuals who have been diagnosed with HIV or AIDS.**
- **Persons with Brain Injury Waiver: For individuals with an injury to the brain..**
- **Supportive Living Program: For individuals who need assistance with activities of daily living but do not require the level of care provided in a nursing facility.**

For more information click here.

Determination of Need (DON) Assessment

Determination of Need (DON) Assessment

Assessment, Eligibility, and Care Plan Development	
Component	**Description**
Purpose of DON	Determine eligibility for waiver services based on functional and cognitive need
Key Assessment Areas	Activities of daily living, mental acuity, impairment level, safety, and support needs
Conducting Agencies	Illinois Department on Aging (IDoA) or Illinois Department of Human Services – Division of Rehabilitation Services (DHS-DRS)
Aetna Care Coordinator Role	May attend assessment, provide member support, and assist with coordination
Outcome if Eligible	Development of a personalized care plan to support safe living at home or in the community

Prior Authorization

HCBS Waiver Prior Authorization

Prior Authorization Requirement
All HCBS waiver services require prior authorization from the managed care organization to align with approved care plans.

Continuity of Care Importance
Providers must continue services during member transitions to avoid disruption and ensure safety.

- ✓ If a member enrolls with the MCO while your services are already in place, the MCO will make every effort to secure authorization within 15 days of the member's enrollment.
- ✓ Do not stop providing services to the member during this period.

Streamlined Authorization Management
MCO staff coordinate authorizations internally, reducing paperwork and administrative burden for providers.

For authorization questions or support, email:
ABH IL Waiver Auth –
ABHILWaiverAuth@AETNA.com

Covered HCPCS Codes
Specific HCPCS codes are covered with prior authorization based on individual member needs and approved care plans.

A9901	S5165
T2003	S5130
S5161	S5170
T1505	T2020
S5100	S5160

Registration and Billing Reminders

Mandatory IMPACT Revalidation

All Medicaid providers must revalidate their enrollment

Important notes

- Starting in September 2024, all providers will be required to revalidate based on their enrollment date.
- Revalidation notices will be sent in rolling stages, and regular every-five-year revalidation will be ongoing. Providers are encouraged to watch their email inbox for revalidation instructions. Currently enrolled Medicaid providers will receive two email notifications: 90 days and 30 days before their Revalidation Due Date.
- Failure to revalidate will result in a provider being removed from Medicaid. When removed, providers will not be able to bill for some of their most vulnerable patients and clients.
- Authorized staff may complete the revalidation on behalf of a provider. Instructions for individuals and organizations are available here.

Need more info?

More information about revalidation — including a list of Frequently Asked Questions — is available from HFS at HFS.Illinois.gov/Impact.

Providers who need assistance completing their revalidation may call HFS Provider Enrollment at: **1-877-782-5565**.

Registration

- Providers must register as an Atypical provider with IMPACT. Prior to rendering services, Atypical providers must ensure that any applicable Medicaid ID(s) are enrolled as Atypical and active. As an Atypical provider, there should **never be an NPI submitted on any claims in any field**.
  - Each unique Medicaid ID will have a specific single Provider Type and the appropriate Category of Service(s) that they are allowed to bill under that unique Medicaid ID.
  - Providers may have multiple active Medicaid IDs. When submitting claims, the provider must ensure they are using the appropriate Medicaid ID for the services being rendered.

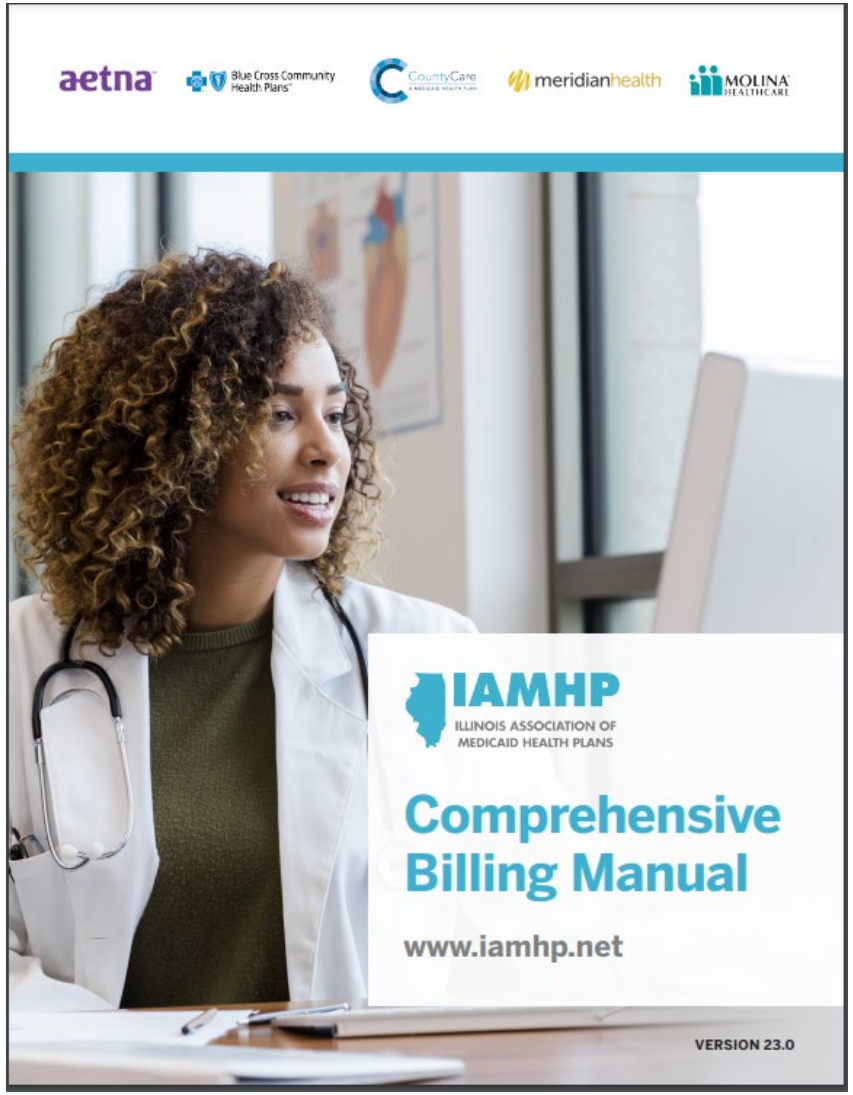
Appropriate Provider Types

HFS Provider Type	HFS Description
090	Waiver service provider--Elderly (IDoA)
092	Waiver service provider--Disability (DHS/DRS)
093	Waiver service provider--HIV/AIDS (DHS/DRS)
098	Waiver service provider--TBI (DHS/DRS)

Appropriate Category of Service

HFS Legacy Category of Service	IMPACT Subspecialty
090	Case Management
091	Home Maker
092	Agency Providers PA, RN, LPN, CAN and Therapist
093	Individual Providers PA, RN, LPN, CAN and Therapist
094	Adult Day Service
095	Habilitation Services
096	Respite care
097	Other HCFA approved services
098	Electronic Home Response/EHR installation

IAMHP Billing Manual



The IAMHP Comprehensive Billing Manual is designed to provide support and guidance to contracted Medicaid managed Care providers on billing services rendered to Medicaid members.

This manual gives providers a one-stop document for billing and claim procedures, without having to look up each health plan and/or provider specific process separately.

The IAMHP billing manual can be found at www.IAMHP.net

HCBS Commonly Billed Services and Requirements

These are not all inclusive but rather the commonly billed HCBS services.

For additional billing guidance, please refer to IAMHP Billing Guide.

- FYI: Providers should not combine CPT codes when each service requires a different taxonomy.

- Example: A provider may not bill a claim with both S5130 and S5170. These should be billed on two separate claims as each service requires a different taxonomy to be present on the claim.

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Homemaker	S5130		15 minutes 1 hour = 4 units	12	Y	Y	Y	Y	91	376J00000X--Homemaker 251E00000X--Home health
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003*		1 unit is 1 trip maximum of 2 daily	99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care
TBI Day Habilitation	T2020		Per Diem 1 day = 1 unit	11, 99				Y	95	261QR0400X--Specialized Rehabilitation 373H00000X--Day Training Habilitation Specialist 251E00000X--Home Health
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period	12		Y	Y	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99		Y	Y	Y	97	332U00000X--Home Delivered Meals
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161*		Per Month	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Automatic Medication Dispenser	A9901		Per Install	12, 99	Y				98	332B00000X--Medical Equipment & Medical Supplies
Automatic Medication Dispenser Monthly	T1505		Per Month	12, 99	Y				98	332B00000X--Medical Equipment & Medical Supplies

Acceptable Provider Types & Categories of Service

Acceptable Provider Types & Categories of Service

Waiver programs that are supported and billed for members assigned to Aetna Better Health of Illinois Medicaid (DRS will communicate when they combine their waivers):

- Persons who are Elderly Waiver
- Persons with Disabilities Waiver
- Persons with HIV or AIDS Waiver
- Persons with Brain Injuries (BI) / Traumatic Brain Injury (TBI) Waiver

Depending on the HCPCs service being rendered, the next slides outline the acceptable and required:

- ✓ Place of service (POS)
- ✓ Category of Service (COS) / Specialty / Subspecialty
- ✓ Taxonomy

If any one of the required components (COS, POS, and taxonomy) are not aligned, the provider will experience appropriate rejections.

Persons who are Elderly Waiver

Acceptable Provider Types & Categories of Service

HFS Provider Type	HFS Description
90	Waiver service provider--Elderly (IDoA)

HFS Legacy Category of Service (COS)	IMPACT Subspecialty
91	Home Maker
94	Adult Day Service
98	Electronic Home Response/EHR installation

Billable Service Codes for Persons who are Elderly Waiver

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service (POS)	Elderly Waiver HFS Provider Type (PT): 90	HFS Category of Service (COS)/ Specialty/Subspecialty	Acceptable Taxonomies
Homemaker	S5130		15 minutes 1 hour = 4 units	12	Y	91	376J00000X--Homemaker 251E00000X--Home health
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003***		1 unit is 1 trip maximum of 2 daily	99	Y	94	261QA0600X--Adult Day Care
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161		Per Month	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Automatic Medication Dispenser	A9901		Per Install	12, 99	Y	98	332B00000X--Medical Equipment & Medical Supplies
Automatic Medication Dispenser Monthly	T1505		Per Month	12, 99	Y	98	332B00000X--Medical Equipment & Medical Supplies

Persons with Disabilities Waiver

Acceptable Provider Types & Categories of Service

HFS Provider Type	HFS Description
92	Waiver service provider--Disability (DHS/DRS)

HFS Legacy Category of Service (COS)	IMPACT Subspecialty
91	Home Maker
94	Adult Day Service
97	Other HCFA approved services
98	Electronic Home Response/EHR installation

Billable Service Codes for Persons with Disabilities Waiver

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service (POS)	Disability Waiver HFS Provider Type (PT): 92	HFS Category of Service (COS)/ Specialty/Subspecialty	Acceptable Taxonomies
Homemaker	S5130		15 minutes 1 hour = 4 units	12	Y	91	376J00000X--Homemaker 251E00000X--Home health
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003***		1 unit is 1 trip maximum of 2 daily	99	Y	94	261QA0600X--Adult Day Care
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161		Per Month	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period	12	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99	Y	97	332U00000X--Home Delivered Meals

Persons with HIV/AIDS Waiver

Acceptable Provider Types & Categories of Service

HFS Provider Type	HFS Description
93	Waiver service provider--HIV/AIDS (DHS/DRS)

HFS Legacy Category of Service (COS)	IMPACT Subspecialty
91	Home Maker
94	Adult Day Service
97	Other HCFA approved services
98	Electronic Home Response/EHR installation

Billable Service Codes for Persons with HIV/AIDS Waiver

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service (POS)	HIV/AIDS Waiver HFS Provider Type (PT): 93	HFS Category of Service (COS)/ Specialty/Subspecialty	Acceptable Taxonomies
Homemaker	S5130		15 minutes 1 hour = 4 units	12	Y	91	376J00000X--Homemaker 251E00000X--Home health
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003***		1 unit is 1 trip maximum of 2 daily	99	Y	94	261QA0600X--Adult Day Care
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161		Per Month	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period	12	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99	Y	97	332U00000X--Home Delivered Meals

Persons with Brain Injuries/Traumatic Brain Injury Waiver

Acceptable Provider Types & Categories of Service

HFS Provider Type	HFS Description
98	Waiver service provider--TBI (DHS/DRS)

HFS Legacy Category of Service (COS)	IMPACT Subspecialty
91	Home Maker
94	Adult Day Service
95	Habilitation Services
97	Other HCFA approved services
98	Electronic Home Response/EHR installation

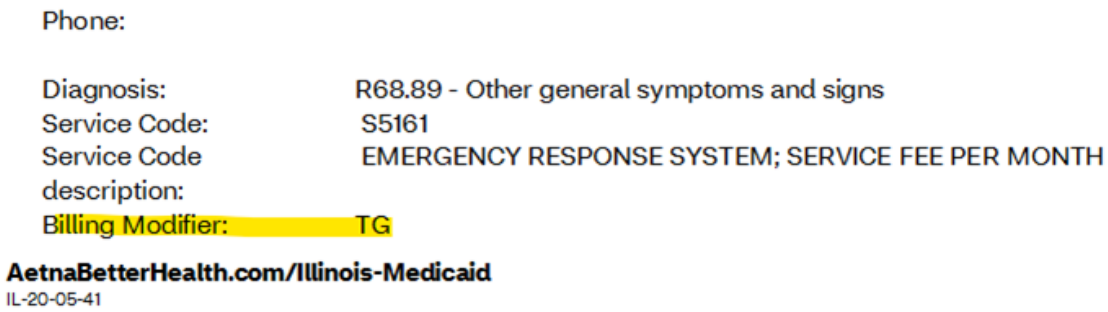
Billable Service Codes for Persons with Brain Injuries/Traumatic Brain Injury Waiver

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service (POS)	Traumatic Brain Injury Waiver HFS Provider Type (PT): 98	HFS Category of Service (COS)/ Specialty/Subspecialty	Acceptable Taxonomies
Homemaker	S5130		15 minutes 1 hour = 4 units	12	Y	91	376J00000X--Homemaker 251E00000X--Home health
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003***		1 unit is 1 trip maximum of 2 daily	99	Y	94	261QA0600X--Adult Day Care
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161		Per Month	12, 99	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period	12	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99	Y	97	332U00000X--Home Delivered Meals
TBI Day Habilitation	T2020		Per Diem 1 day = 1 unit	11, 99	Y	95	261QR0400X--Specialized Rehabilitation 373H00000X--Day Training Habilitation Specialist 251E00000X--Home Health

EHRS

EHRS/TG Modifier Requirements

EHRS has expanded options for AGING WAIVER members only. If you receive an auth with the modifier identified, we are asking for an enhanced service, and it will look like this:


Phone:

Diagnosis: R68.89 - Other general symptoms and signs
Service Code: S5161
Service Code description: EMERGENCY RESPONSE SYSTEM; SERVICE FEE PER MONTH
Billing Modifier: TG

AetnaBetterHealth.com/Illinois-Medicaid
IL-20-05-41

Things to Consider

- **Installer Conduct**
  - ✓ Installers must follow only authorized procedures.
  - ✓ They should **not** attempt to persuade members to switch to the enhanced service.
  - ✓ If installers are unfamiliar with basic EHRS installation, **do not assign them** to basic install jobs for Aetna members.
  - ✓ This helps prevent inappropriate upgraded installs.

- **Billing Requirements**
  - ✓ Please ensure that the **claim modifier matches the authorization modifier**. Any discrepancies between the two will result in claim denial.
  - ✓ If billing for **enhanced EHRS** without authorization, the claim will also be rejected.

Transportation Billing

Transportation Billing - T2003

Aetna Better Health® of Illinois has specific billing requirements when billing T2003 for a round trip. The Illinois Association of Medicaid Health Plans (IAMHP) billing manual includes the following Aetna Better Health of Illinois requirements.

- Claims must be billed with a maximum of 2 units per line for each date of service provided.
- When submitting corrected claims, please include any additional services that were billed on the original claim.
- **T2003:** when billing a round trip, the round-trip service must be billed on one line for each trip date.

HFS Provider Type	HFS Description
90	Waiver service provider--Elderly (IDoA)
92	Waiver service provider--Disability (DHS/DRS)
93	Waiver service provider--HIV/AIDS (DHS/DRS)
98	Waiver service provider--TBI (DHS/DRS)

HFS Legacy Category of Service (COS)	IMPACT Subspecialty
94	Adult Day Service

Correct Billing Example

DOS From	DOS To	POS	HCPCS	Units
7.1.22	7.1.22	99	T2003	2
7.2.22	7.2.22	99	T2003	2
7.3.22	7.3.22	99	T2003	2

Incorrect Billing Example

DOS From	DOS To	POS	HCPCS	Units
7.1.22	7.3.22	99	T2003	6
7.1.22	7.30.22	99	T2003	60

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service (POS)	Elderly Waiver HFS Provider Type (PT): 90	Disability Waiver HFS Provider Type (PT): 92	HIV/AIDS Waiver HFS Provider Type (PT): 93	Traumatic Brain Injury Waiver HFS Provider Type (PT): 98	HFS Category of Service (COS)/ Specialty/Subspecialty	Acceptable Taxonomies
Adult Day Care Transportation	T2003		1 unit is 1 trip maximum of 2 daily	99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care

Home Modification Billing

Home Modification-S5165

S5165- is priced based on your authorization approval letter, this process differs from the other waiver services.

Please be sure to upload your authorization approval letter and invoice for more accurate and expedient claims processing.

HFS Provider Type	HFS Description
92	Waiver service provider--Disability (DHS/DRS)
93	Waiver service provider--HIV/AIDS (DHS/DRS)
98	Waiver service provider--TBI (DHS/DRS)

HFS Legacy Category of Service (COS)	IMPACT Subspecialty
97	Other HCFA approved services

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service (POS)	Disability Waiver HFS Provider Type (PT): 92	HIV/AIDS Waiver HFS Provider Type (PT): 93	Traumatic Brain Injury Waiver HFS Provider Type (PT): 98	HFS Category of Service (COS)/ Specialty/Subspecialty	Acceptable Taxonomies
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period	12	Y	Y	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor

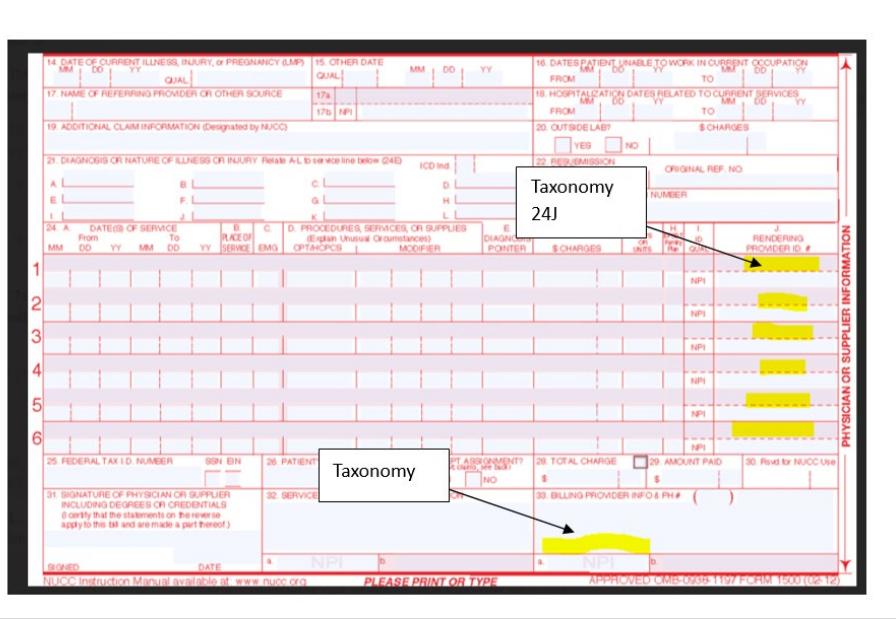
Rejections and Denials

Top 5 Waiver Provider Rejections

These rejection codes and the corresponding description can be used to explain the rejection code to the provider and how to resolve for successful adjudication.

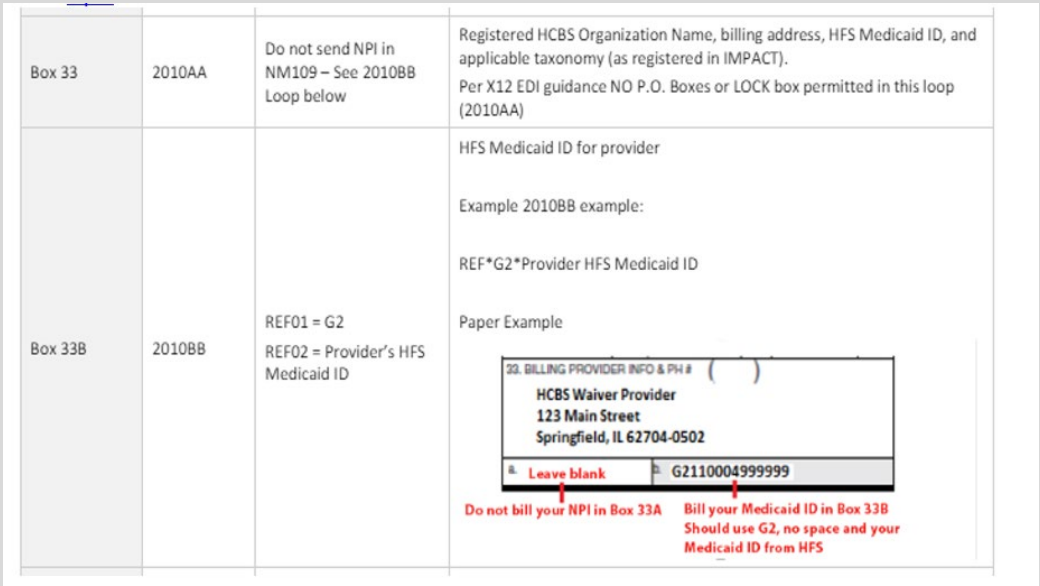
Provider Facing Rejection Code	Description	Explanation
A3	Claims submitted to incorrect payer	Incorrect payor ID
A3	Rendering Medicaid ID not on State File	Rendering Medicaid ID not on State File
A3 **QC Patient 26**	Acknowledgement/Returned as processable claim-The claim/encounter has been rejected and has not been entered into the adjudication system Entity not found. Usage: This code requires use of an Entity Code	Member's information entered does not match information in the health plan system (Incorrect ID, DOB, SS, etc)
A3 **.25**	Acknowledgement/Returned as processable claim-The claim/encounter has been rejected and has not been entered into the adjudication system Entity not approved. Usage: This code requires use of an Entity Code250 - Type of service	HCBS is not an acceptable provider type for the service billed (Incorrect Medicaid ID/ provider type)
A3 **562 -**	-Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system. Entity's National Provider Identifier (NPI). Usage: This code requires use of an Entity Code.	Provider set-up needs to be reviewed. Confirm set-up as Atypical with Clearinghouse and confirm ABHIL has set-up correctly.

Common Waiver Provider Denials and Resolution

Denial Code Description	Resolution
8 –THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY) **N94** - Claim/Service denied because a more specific taxonomy code is required for adjudication. **N255** - Missing/incomplete/invalid billing provider taxonomy.	The taxonomy needs to map to the correct provider type and service being rendered. The taxonomy should also be listed in Box 24J or Box 33. To view the appropriate taxonomy please review the IAMHP Billing Guide for the mapping of taxonomy to provider type and HCPC / CPT code.  ***The taxonomy is **required** on all claims

Common Waiver Provider Denials and Resolution Cont.

Denial Code Description	Resolution
185 – THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE SERVICE BILLED **299** - THE BILLING PROVIDER IS NOT ELIGIBLE TO RECEIVE PAYMENT FOR THE SERVICE BILLED	Provider may receive this denial if claim is being submitted with an NPI or the incorrect Medicaid ID is being used. IAMHP Billing Guidelines Pg. 228 - 239, Home and Community Based Health (HCBS) Waiver Providers: Click Here



Box 33	2010AA	Do not send NPI in NM109 – See 2010BB Loop below	Registered HCBS Organization Name, billing address, HFS Medicaid ID, and applicable taxonomy (as registered in IMPACT). Per X12 EDI guidance NO P.O. Boxes or LOCK box permitted in this loop (2010AA)
Box 33B	2010BB	REF01 = G2 REF02 = Provider's HFS Medicaid ID	HFS Medicaid ID for provider Example 2010BB example: REF*G2*Provider HFS Medicaid ID Paper Example

***The NPI **should not** be present anywhere on the claim, HCBS provider can only bill using their appropriate Medicaid ID.

Common Waiver Provider Denials and Resolution Cont.

Denial Code Description	Resolution
M62 – Missing/incomplete/invalid treatment authorization code. **198** –PRECERTIFICATION/NOTIFICATION/AUTHORIZATION/PRE-TREATMENT EXCEEDED **197** – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT **N54** - CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES. **39** - SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED **N758** - ADJUSTED BASED ON THE PRIOR AUTHORIZATION DECISION	These codes are all related to an authorization denial, please review the authorization and confirm the services being billed were authorized for the dates of service being billed on the claim. HCBS services are authorized on a monthly basis, if claims are over billed the extra units are denied. For example, if services are authorized for 50 units per month and the provider bills 75 units per month, the claim will deny the additional 25 units.
96 -NON-COVERED CHARGE(S)	Non-covered charge(s). Item does not meet the criteria for the category under which it was billed.
N767 - THE MEDICAID STATE REQUIRES PROVIDER TO BE ENROLLED IN THE MEMBER'S MEDICAID STATE PROGRAM PRIOR TO ANY CLAIM BENEFITS BEING PROCESSED. **208** - NATIONAL PROVIDER IDENTIFIER - NOT MATCHED	Confirm the correct Medicaid ID is being billed with the correct provider type and that provider is registered in IMPACT appropriately.

Connect Center Billing

Connect Center Billing

CHANGE HEALTHCARE ConnectCenter

ConnectCenter provides the ability to create a CMS 1500 professional claim through the Claims menu by selecting the Create a Claim option. Please note that there are minimum field requirements to submit a basic valid claim.

For detailed guidance, including instructions for A-typical providers (see pages 13–15), please click here.

ABH of IL Payer ID is 68024. Our **Vendor Code 214568**

To sign in or register for ConnectCenter, please use the following link: ConnectCenter for partners - Connect Center

Support Contacts
- Phone Support: 800-527-8133, Option 2
- Email Support: assuranceedi.support@optum.com

Bill IQ

Bill IQ: Medicaid Billing

Introduction

Bill IQ is a conversational AI provider support agent designed to help Medicaid providers seamlessly navigate the complex landscape of Illinois Medicaid billing guidelines.

Here are some FAQs related to Bill IQ:

1. What is Bill IQ?
Answer: Bill IQ is a conversational AI tool developed by Everlign to help users quickly find answers to billing-related questions. Right now, it is focused on helping users understand billing rules and policies based on the **Illinois Association of Medicaid Health Plans (IAMHP) Billing Manual**.

2. What kind of questions can I ask Bill IQ?
Answer: You can ask questions related to billing guidelines that can be sourced directly from the IAMHP Billing Manual. An example question could be "are there any exceptions to this rule regarding therapeutic procedures and office visits?

3. What kind of questions can Bill IQ not answer right now?
Answer: Currently, Bill IQ cannot:

- Answer questions about specific claims (e.g., "Why was my claim denied?")
- Provide information that is not included in the IAMHP Billing Manual
- Access or interpret member or provider-specific data.

4. Why can't Bill IQ answer my question about a rejected claim?
Answer: At this stage, Bill IQ is only trained to answer questions based on the IAMHP billing manual. It does not have access to individual claims data or case-specific systems.

5. Will Bill IQ get smarter over time?
Answer: Yes! This is a soft launch. We plan to expand Bill IQ's capabilities by adding more data sources - such as provider notices, policy bulletins, and potentially FAQs from payer portals. As more content is added, Bill IQ will be able to answer a broader set of questions.

6. How can I tell where Bill IQ is getting its answers from?
Answer: Bill IQ always tells you the source of its answers. For now, all answers come from the IAMHP Billing Manual. When we add new sources, those will also be clearly cited.

7. Is my data being stored or tracked when I use Bill IQ?
Answer: ***No personal health or claims information is used or stored by Bill IQ***. It simply answers general billing questions based on public or shared resources.

8. Who do I contact if I have issues or need support using Bill IQ?
Answer: Please reach out to our claims specialist by emailing us at: *ABHILClaimSpecialist@aetna.com*.

Link: https://abhil.everlign.com/billiq

Contact Us

Aetna Better Health of Illinois
abhilclaimspecialist@aetna.com

aetna

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) Requirements

Electronic visit verification (EVV) is a technology-based system that efficiently verifies home healthcare visits. It collects information by capturing time, location, and attendance of home care workers.

A federally mandated requirement, EVV reduces the likelihood of error while promoting program integrity through a practical and simple monitoring system.

Essential EVV Links, Enrollment Requirements, and Provider Support

Please keep yourself informed and compliant with EVV requirements. Make sure you review all essential EVV information by visiting the provided resources.

- ✓ Staying up to date with these materials will help ensure ongoing compliance and understanding of EVV processes and expectations.

RESOURCE	PURPOSE	LINK / CONTACT
HFS EVV Website	Statewide EVV implementation info, Townhall webinars, notices, MCO contacts	https://hfs.illinois.gov/medicalproviders/electronicvisitverification.html
HFS Provider Notices	Sign up for EVV-specific provider notices and emails	Select "Electronic Visit Verification" category https://hfs.illinois.gov/medicalproviders/notices/provideremailsubscribe.html
HFS EVV Email	State Plan Medicaid HHCS EVV policy inquiries	HFS.EVV@illinois.gov
IDoA EVV Email	IDoA EVV policy inquiries	Aging.EVV.Support@Illinois.gov
DRS EVV Email	DRS EVV policy inquiries	DHS.EVV@Illinois.gov
HHA Illinois Information Pages	Guidance for providers serving DDD, DSCC, State Plan Medicaid, DRS, and IDoA	https://www.hhaexchange.com/info-hub/illinois
HHA Provider Enrollment Survey	Required portal setup for all providers	Illinois - HHAeXchange Provider Enrollment Form
HHA Provider Support	Technical and operational assistance	Customer Support Portal / IL Line: 1-(646)-821-8784

Important Links

Important Links

- ❑ Access listing of assigned Network Relations Sr. Analysts & Managers
- ❑ IAMHP Comprehensive Billing Manual
- ❑ HFS' IMPACT Provider Registration
- ❑ HCBS waiver reminders – February 2024 ABHIL Provider Notice
- ❑ T2003 Billing Update – September 2022 ABHIL Provider Notice

Aetna Medicare FIDE (HMO D-SNP)

Aetna Medicare FIDE/HMO D-SNP – Important Clarification

While our team **does not** handle the Aetna Medicare FIDE/HMO D-SNP plan, we only support Aetna Better Health of Illinois Medicaid inquiries. We want to ensure that your inquiries regarding the Aetna Medicare FIDE/HMO D-SNP plan are addressed timely and accurately.

To support you, we have listed the appropriate contact information and a resources chart.

- ✓ If you have any questions related to the Aetna Medicare FIDE/HMO D-SNP plan, please reach out to their team for assistance.

Aetna Medicare FIDE (HMO D-SNP) Contact & Resource Quick Reference Chart		
Resource Name	**Purpose**	**Link / Contact**
Quick Reference Guide (QRG)	Key contacts and workflows for FIDE/HMO D-SNP inquiries	https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/pdf/IL%20FIDE%20QRG%20-2026.pdf
Frequently Asked Questions (FAQ)	Common questions and guidance for FIDE/HMO D-SNP	https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/pdf/IL%20FIDE%20FAQ%20-%202026.pdf
Authorization Contact	For Waiver AUTH-related inquiries	**Email:** ILFIDECM@aetna.com
Aetna Medicare FIDE (HMO D-SNP) – Phone Number	Provider support line	**1-866-600-2139**
Aetna Medicare FIDE (HMO D-SNP)– Provider Site	Provider tools, forms, and resources	*https://www.aetnabetterhealth.com/illinois/providers/*
Provider Relations Email	General provider relations inquiries	COEProviderServices@AETNA.com

Thank you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