Aetna Better Health Webinar Series

Provider Network Relations
Network Relations Team

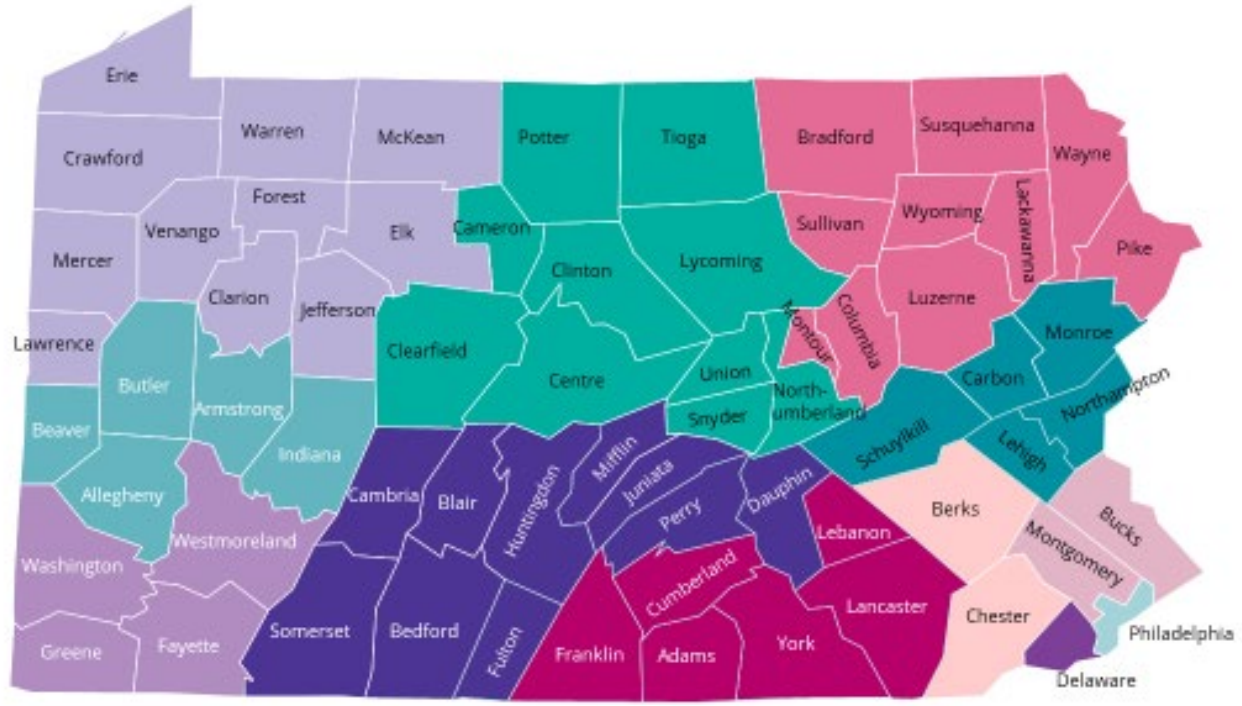
March 2021

As a team, we are committed to supporting our providers and working together toward positive outcomes for your patient, our member.

— YOUR NETWORK RELATIONS TEAM

Network Relations Consultants Territory Map & List

Network Relations Consultant Territory Map



Sherrie Flannery	Melinda Roach	Kim Heggenstaller	Kari Heggs
Vacant	Michelle Bogard	Jacelyn Cressman	Teresa Washington / Anna DiPietro
Vacant	Michael Quinn	Kimberly Young	Teresa Washington Including FQHC/RHC
			All FQHC/RHC – Teresa Washington

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Proprietary

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Source: https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/PRBios%20PA_09182020%20Updated.pdf

Large Group & Hospital Assignments

Provider Group	Representative
Advocare Pediatrics	Kari Heggs
Allegheny Health Network	Vacant
Children's Hospital of Phila.	Teresa Washington
Coordinated Health	Vacant
Crozer Keystone	Teresa Washington
CVS MinuteClinic	Kari Heggs
Detweiler Family Medicine	Kimberly Young
Drexel Medicine	LaShawn Bailey
Einstein Health Network	Anna DiPietro
FQHC's	Teresa Washington
Geisinger	Kim Heggenstaller
Jefferson Health	Anna DiPietro
Lehigh Valley Health Network	Jaclyn Cressman

Provider Group	Representative
Trinity (Mercy) Health	Kari Heggs
Nemours	Teresa Washington
Penn State Health	Kimberly Young
Phoenix Rehabilitation & Health Services, Inc.	Vacant
Quest Diagnostics	Kari Heggs
St. Christopher's	Kimberly Young
St. Mary Medical Center	Kari Heggs
Tower Health	Kimberly Young
UPMC Cole	Melinda Roach
UPMC Pinnacle	Michelle Bogard
UPMC Susquehanna	Melinda Roach
UPMC – Western PA	Melinda Roach
WellSpan Health	Michael Quinn

Experience:

Sherry has over 15 years in the health insurance industry. Her experience includes marketing and provider relations. She is a team player and is always volunteering her services when needed.

Territory:

Her territory is in the northwest and includes Erie, Warren, McKean, Crawford, Venango, Forest, Elk, Clarion, Jefferson, Mercer and Lawrence Counties.

More about Sherrie:

She lives in Warren County with her husband and two teenage children. She enjoys time with family and friends and attending her kids' activities. She keeps busy volunteering with First Lutheran Church, the Alzheimer's Association, Head Start Policy Council, the Eldercare Council and Crime Stoppers of Warren County.

Sherrie Flannery

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Agenda

Claims and Billing Tips for Successful Outcomes

- National Correct Coding Initiative (NCCI) edits
- PROMISe Billing Requirements
- Rendering/Referring NPI Billing Requirements
- Provider Facility Code Requirements
- Timely Filing Guidelines
- Common Modifiers
- Multiple Surgical Guidelines
- Inpatient Hospital Services
- Ambulatory Surgery Centers
- Coordination of Benefits (COB)
- Submitting Encounter Data
- DHS Medicaid Fee Schedules
- Injectable Drugs
- Additional Billing Related Information
- Updating Provider Demographic Information

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- Claim Submission Format
- Claims Resubmissions
- Corrected Claims
- Submitting Medical Records
- Filing a Claim Appeal
- Provider Call Center
- Prior Authorization
- Billing Guides, Handbooks & Resources
- Quick Reference Billing Guide

Presenter: LaShawn Bailey

Introduction

Billing and Claims Quick Reference Guide

This information is useful to providers and staff to aid in the understanding our health plan's billing protocols and to ensure timely and accurate payment for eligible covered services.

Note: Aetna Better Health of PA incorporates the National Correct Coding Initiative (NCCI) edits into it's claim policy and procedures as announced by PA DHS MAB 99-11-10.

NCCI was developed by CMS to promote national correct coding methodologies and to control improper payment in outpatient claims. NCCI has two components:

- Procedure to Procedure (PTP) edits
- Medically unlikely (MUE) edits

In accordance with the Patient Protection and Affordable Care Act (ACA) and as a State Medicaid Managed Care Organization (MCO) Aetna Better Health of PA has incorporated NCCI methodologies in its claims processing systems.

PROMISe Billing Requirements

Providers must be enrolled in Pennsylvania's Medicaid (MA) program and obtain a valid PROMISe ID

To enroll or validate PROMISe ID's use this link: **https://provider.enrollment.dpw.state.pa.us/**

MA & CHIP providers must have a PROMISe ID for every service location in which they operate

DHS uses the NPI & taxonomy submitted on claims to validate enrollment of providers in PROMISe

The NPI, taxonomy and Zip+4 submitted on the claim is used to identify registered service locations

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Billing Requirements – Rendering/Referring NPI

Rendering Provider

- When the rendering provider is the same entity as the billing provider, the rendering provider should be omitted.
- Rendering providers must be individual providers who bill with their individual NPI and taxonomy code.
- Please refer to the *Rendering Providers Must Be Individuals for Certain Provider Types* notice for exceptions.

Referring Provider

- The referring provider should not be the same as the rendering provider.
- If a referring provider is not required, then it should not be billed.
- The referring provider should not be the billing or rendering provider.

Provider Registration

- As of July 1, 2019, all Medicaid and CHIP providers who render services for Medicaid or CHIP beneficiaries must be enrolled with DHS and have a valid PROMISe Id for each service location at which a provider operates.
- DHS uses the NPI number, ZIP+4 and taxonomy submitted on claims to validate the enrollment of providers in PROMISe.
- Physicians and other practitioners that order, refer or prescribe items or services to MA beneficiaries should also be enrolled as participating providers.

Source: https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/notices/ESC%201232%20Notice.pdf

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Provider Facility Code Requirement

When a service is provided in a facility and the provider is submitting a professional claim, the service facility information must be submitted. Specific claim requirements include:

- Facility NPI and address must be submitted for professional claims billed for services rendered at a facility POS 19, 21-24, 31 & 32
- The service facility location must be populated in Loop 2310C Segment NM109
- Service facility location name, address and nine digit zip in box 32 on the CMS1500
- Service facility location NPI in box 32a on the CMS 1500
- If facility location information is not on the claim, the claims will deny
- If the facility number is not numeric or is missing and the POS is 21, 22, 23, 24,31 or 32, the claim will deny
- If services are not actually performed at a facility for a recipient, the POS should not be 21, 22, 23, 24, 31 or 32

Source: https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/Provider%20Facility%20CODE_Req_Web_V2_%20(4)%20(2)FINAL.pdf

Timely Filing Guidelines

These filing deadlines are applicable unless otherwise specified in your provider contract.

Initial Claims

- 180 days from the date of service

Corrections

- 365 days from the date of the provider remittance

Appeals

- 60 days from the date of the notification

Source: https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/packet/provider-timely-submission-guide%2020104.pdf

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Common Modifiers

It is important to bill the appropriate modifier with claims to avoid denials.

Displayed are a few common modifiers to consider.

Modifier 25

- Use to append an evaluation and management (E&M) service
- Identifies a significant, separately identifiable E&M service

Modifier 59

- Distinct procedural service
- Used to identify E&M procedures that are not typically reported together

Modifier 50

- Bilateral procedure
- Indicate 2 units on claim

Multiple Surgical Guidelines

Claims will be processed using the following multiple surgical guidelines.

For more information, please see the link the P.A. code and bulletin below or visit the DHS website.

Professional Billing

- 100% for the highest allowable payment
- 25% for the second highest allowable payment
- 0% (no payment) for additional procedures

Facility Outpatient Billing

- 100% for the highest paying procedure
- 0% (no payment) for additional procedures

Source: http://www.pacodeandbulletin.gov/

Inpatient Hospital Services

Claims must be billed according to the applicable APR DRG Version.

For more information, please link into the full communication below.

Effective 10/1/2018

- APR DRG Version 36
- Inpatient services with discharges on or after October 1, 2018

Effective 10/1/2019

- APR DRG Version 37
- Inpatient services with discharges on or after October 1, 2019

Source: https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/notices/apr-drg-ver37-notice-2020_SP_FINAL.pdf

Ambulatory Surgical Centers

All Ambulatory Surgery Centers billing on a UB-04 for services should use bill type 08XX and not 013X used for outpatient facilities.

First Digit
- Type of Facility
- Always enter “8” to indicate special facility

Second Digit
- Bill Classification
- Enter “3” to indicate outpatient or 4 for hospital special treatment room

Third Digit
- Frequency
- Enter “0” – Non-Payment /Zero Claim
- Enter “1” – Admit through discharge claim
- Enter “7” – Replacement of a prior claim

Source: https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/notices/UB_O4BillingAmbulatorySurgCentersSP_FINAL.pdf

Coordination of Benefits

Aetna Better Health is the primary payer on the following services:

Preventative Care

Prenatal or preventative pediatric care (including EPSDT services), and services to children having medical coverage under a Title IV-D child support order.

Aetna Better Health is generally the “payer of last resort” on all other services. Providers must bill third party insurance before submitting the claim.

Providers must submit the Explanation of Benefits (EOB) from the primary carrier to avoid claim denials.

Aetna Better Health will pay the difference between the primary insurance payment and the allowable amount.

Note: Members may not be balance billed.

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Submit Encounter Data for All Services

DHS requires Aetna Better Health to receive all encounter data to accurately capture member utilization

It is important that DHS is aware of the services rendered for Medicaid services.

For more information on the importance of encounter data, please see link to the full communication below.

- To determine Hospital Quality Incentive Payments (HQIP) using submitted inpatient and outpatient data

- To ensure service records for HEDIS measures are accurately collected.
- For HEDIS indicators, payment is not considered. HEDIS is based on utilization only procedure code

To ensure children are receiving EPSDT services as part of Aetna Better Health's clinical oversight.

Source: https://www.dhs.pa.gov/providers/Providers/Pages/Hospital-Assessment-Initiative-.aspx

Medicaid (MA) Fee Schedules

We reimburse providers according to the Medicaid (MA) fee schedules or other contracted rates.

The Medicaid (MA) fee schedules can be found on the Department of Human Services (DHS) website. To access, please visit the DHS website or click the link:

- https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Fee-Schedule.aspx

Your contract contains your reimbursement information. If you have questions, you may contact your Provider Relations Representative.

Injectable Drugs

All injectable drugs should be submitted with the NDC code and a valid HCPCS code.

- The injectable drugs must be rebate-able in order to receive payment
- The N4 qualifier should proceed the NDC number
- The NDC unit of measure (F2, GR, ML, UN)
- NDC units dispensed must be greater than 0
- To determine if an injectable is rebate-able either of the following:
  - https://www.reimbursementcodes.com/
  - https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e/data

Additional Billing Related Information

Anesthesia
- Services must be reported using anesthesia ASA procedure codes
- All services should be billed in minutes

Chiropractic Services
- Claims should be submitted using the CMS 1500 form or via 837 electronic format
- Covered services include exam and manipulation of the spine.
- Non-Covered services include physical therapy

Durable Medical Equipment (DME)
- Claims should be submitted using the CMS 1500 form or via 837 electronic format
- DME rental claims are only paid up to the purchase price of the equipment

Family Planning
- Eligible services must be billed with the “FP” modifier

OP Hospital

All revenue codes billed on an outpatient UB-04 require a corresponding HCPCS code.
Rev Code 710 is not a billable code for outpatient facility claims

Skilled Nursing Facility (SNF)

FAQ’s for eligible CHC members regarding Skilled Nursing Facility services can be found in the following Aetna Better Health notification: aetnabetterhealth.com/pennsylvania/providers/notices, click on FAQs and select the Skilled Nursing Facility notice

Updating Demographic Information

Network Providers should contact their Provider Relations Consultant or Provider Services with changes to their demographic information.

Network Providers may verify their demographic data at any time using the “real-time” Provider Network directory at https://www.aetnabetterhealth.com/pennsylvania/find-provider.

Requests for changes to address, phone number, tax I.D., or additions and/or deletions to group practices must be made through the on-line the Provider Change Form:
https://medicaidportal.aetna.com/mcainteractiveforms/ProviderForms/ProviderDemographicChangesForm.aspx

You can also update us via a paper change form:

Change forms can be emailed to ABHProviderRelationsMailbox@AETNA.com

Or mail to:

Aetna Better Health/Aetna Better Health Kids
Attention: Provider Relations
1425 Union Meeting Road
Blue Bell, PA 19422

Claim Submission

Claim Submission Format

Claims should be submitted using the appropriate forms to avoid claim denials.

Professional
- Submit via CMS 1500 or via 837P format

Institutional Facility
- Submit via CMS 1450 (UB-04) or via 837P format

Claim Resubmission

We require providers to submit initial claims within 180 calendar days from the date of service.

Claims resubmissions must be received no later than 365 calendar days from the date of the Provider Remittance Advice or EOB if the initial submission was within the 180 calendar day period, whether or not the initial claim was denied.

These guidelines are applicable unless otherwise specified in the terms of your contract.

- When submitting corrected claims, please include all required information
- Previously submitted claims which require attachment of additional information
- Submit within the contracted timely filing guidelines
- Can be submitted electronically through EDI when supporting documentation is not required
- Claims must be submitted on paper to our processing center when supporting documentation is required
- When resubmitting claims, please indicate on the form whether it is a corrected claims or a resubmission with supporting documentation

Corrected Claims

A corrected claim is a resubmission of a previously processed claim with at least one change (e.g., modifier, service line, diagnosis etc.)

Important reminders when submitting corrected claims:

- Make the necessary change to the claim to avoid duplication
- Submit within 365 days of the original remittance date
- Add the original claim number on the claim form
- Submit with the appropriate bill type
- Original paper claims must be resubmitted via paper
- Entire claim must be resubmitted

These guidelines are applicable unless otherwise stated in your provider agreement.

Submitting Medical Records

When submitting medical records solicited by Aetna Better Health of Pennsylvania, please include a cover sheet with the following information:

- Provider information (NPI or provider id#)
- Patient information (name, DOB, health plan identification number)
- Applicable claim information (claim number and date of service)

The medical records can be submitted via:

- Secure web portal accessible via our website, or
- Mail to Aetna Better Health, P O Box 62198, Phoenix, AZ 85082-2198

For instructions on submitting medical records and supporting documentation via the web portal, please review the step-by-step guide for adding attachments under the portal section of our website or click below.

Source: Adding Portal Attachments

Filing an Appeal

An appeal is a formal post service expression of dissatisfaction in which a provider requests that ABH change an adverse determination for care or services rendered to a member.

When submitting an appeal, be sure to:

1. Use the Appeal Form to submit your appeal in writing to the Appeals & Grievance department

2. State the factual basis for the relief requested.

3. Include all supporting documentation such as claim, medical records, office notes, operative notes, remittance advice and any other substantial documentation.

IMPORTANT: Failure to specifically state the factual basis of the appeal and/or failure to submit supporting documentation may result in denial of the provider appeal. The Provider Clinical Appeals committee reviews all appeals and makes the final determination.

Resources

Provider Call Center

Claims Inquiry & Claims Research (CICR) team

The CICR team can assist you with claim related questions and concerns. Their enhanced broad service model includes, but is not limited to calls related to:

- Billing or contract related questions
- Assistance with claim status and troubleshooting issues
- Explaining the claim process and adjudication procedures
- Claim remittance advice, EOB's and check reconciliation
- Navigation through our secured web portal

The CICR staff is available to assist 8 AM-5 PM, Monday-Friday. Just call **1-866-638-1232**

Prior Authorization

The Prior Authorization department is available 24 hours a day, 7 days a week

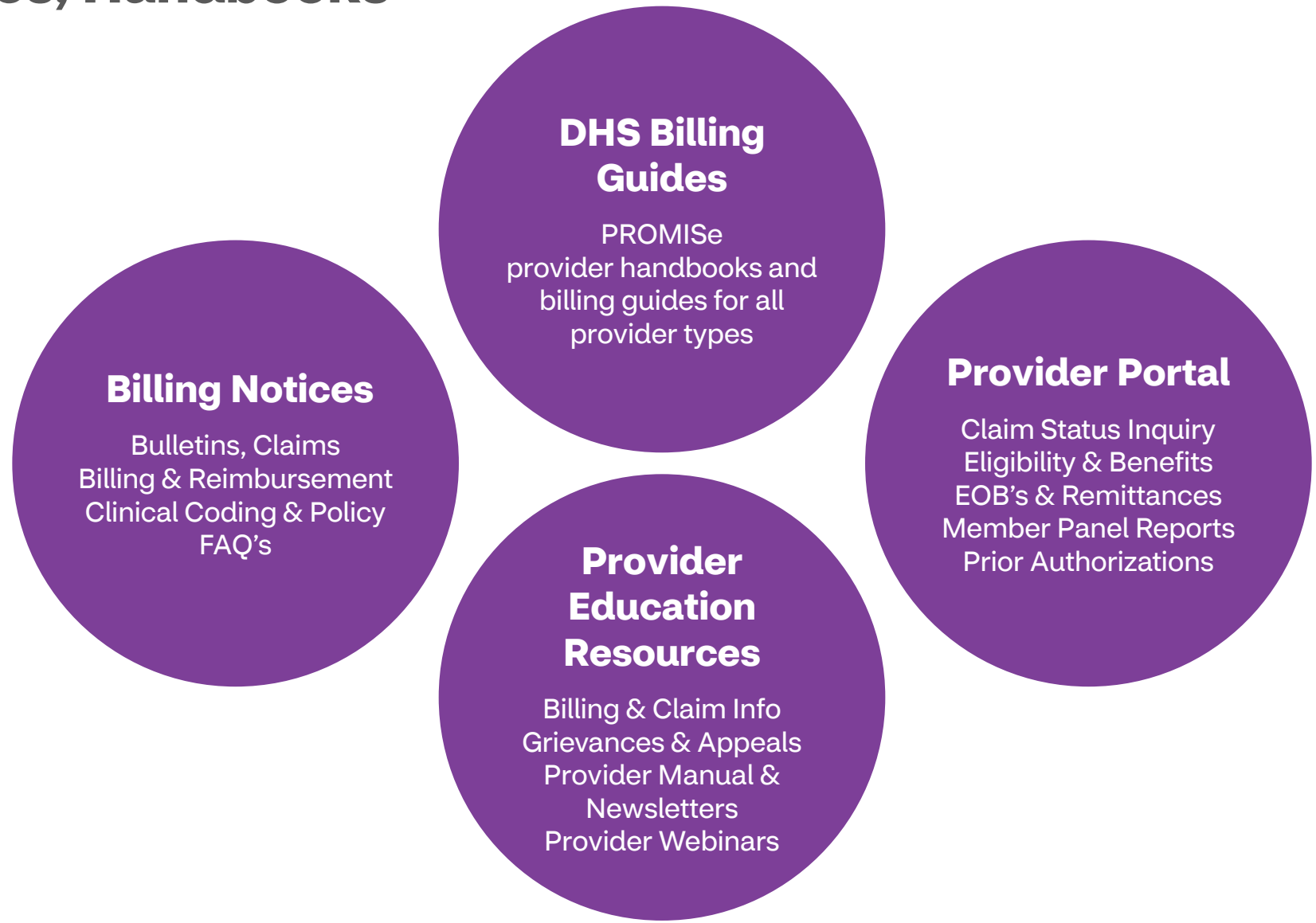
Medical Prior Authorization (MA and CHIP)	
Phone	1-866-638-1232
Fax	1-877-363-8120
Inpatient	1-877-619-5871
Private Duty Nursing	1-877-787-5168

Tips for requesting authorization:

- Always verify member eligibility prior to providing services
- Complete the prior authorization form
- Attach supporting documentation when submitting
- Submit service authorizations through our secure web portal or fax to number above
- Use this helpful prior auth checklist when filling out and submitting a prior authorization request form

Source: https://www.aetnabetterhealth.com/pennsylvania/providers/guidelines

Provider Guides, Handbooks & Resources



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Quick Reference Guide

Appeals	Complaints Grievances & Appeals 1425 Union Meeting Road Blue Bell, PA 19422 Email: PAMedicaidAppeals&Grievance@aetna.com Fax: 1-860-754-1757
Claims Address	Aetna Better Health of Pennsylvania P.O. Box 62198 Phoenix, AZ 85082-2198
Claims Inquiry Claims Research (CICR) Call Center	Phone: 1-866-638-1232
EDI Payer Identification Number	23228
EFT & ERA Form Link	https://www.aetnabetterhealth.com/pennsylvania/providers/forms

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eviCORE • Cardiology • Pain Management • Radiology	Phone: 1-888-693-3211 Fax: 1-844-822-3892 Website: www.eviCore.com
Mailing Address, Phone	Aetna Better Health of Pennsylvania 1425 Union Meeting Road Blue Bell, PA 19422 Phone: 1-866-638-1232
Prior Authorization	Phone: 1-866-638-1232 Fax: 1-877-363-8120
Provider Education Resources	Website: https://www.aetnabetterhealth.com/pennsylvania/providers/ education
Provider Web Portal	Website: https://www.aetnabetterhealth.com/pennsylvania/providers/portal


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