



Billing and Claims Processing



Introduction

Submitting a claim correctly the first time increases the cash flow to your practice, prevents costly follow-up time by your office or billing staff, and reduces the uncertainty members feel with an unresolved claim.

To support that effort, we have multiple options available for our providers to choose from, including our Availity provider portal.

We will guide you through the **Availity Provider Portal** registration process and then we will walk through our **claims process**.

Life of a Claim



Before we get started: Basic Concepts

The two most common claim forms are the CMS-1500 and the UB-04.

The **UB-04** (CMS 1450) is a claim form used by hospitals, nursing facilities, in-patient, and other facility providers. A specific facility provider of service may also utilize this type of form.

The **HCFA-1500** (CMS 1500) is a medical claim form used by individual doctors & practices, nurses, and professionals, including therapists, chiropractors, and out-patient clinics. It is not typically hospital-oriented.

Each paper claim form has an equivalent electronic counterpart, identified below.

	Paper	Electronic
Professional Services	HCFA1500 or CMS1500	837p
Institutional and Organizational	UB-04	837i

Before we get started: Common Terminology

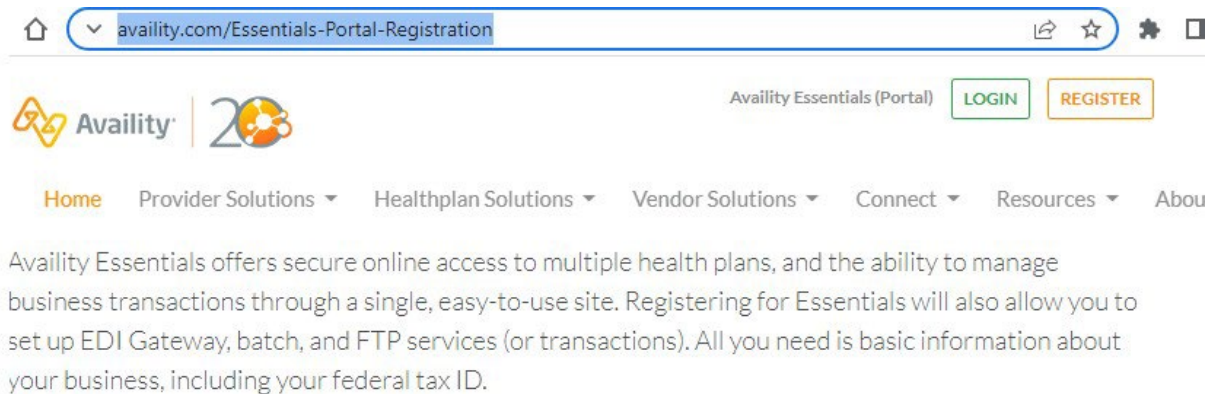
Fee Schedule	List of fees used to reimburse doctors or other providers/suppliers for their services on a fee-for-service basis
CPT	C urrent P rocedure T erminology (Procedures and service codes)
HCPCS	H ealthcare C ommon P rocedural C oding S ystem
ICD10:	Codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
Modifier	a code that provides the means by which a provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code
Edit	Logic within the claims processing system that evaluates information on the claims and depending on the evaluation, takes action on the claims, such as pay in full, pay in part, or suspend for manual review.
Share of Cost	The cost for medical care that the member pays like a copayment, coinsurance, or deductible
Spend Down	A portion of health coverage that an individual must pay for before Medicaid coverage begins.
EDI	E lectronic D ata I nterface
QNXT	Aetna's Claims Processing System

Availity Provider Portal: Registration

In order to start using the Availity Provider Portal you will first need to register.

In your web browser type in: <https://availity.com/Essentials-Portal-Registration>

Click on the **Providers** button as indicated below in red to get stated.

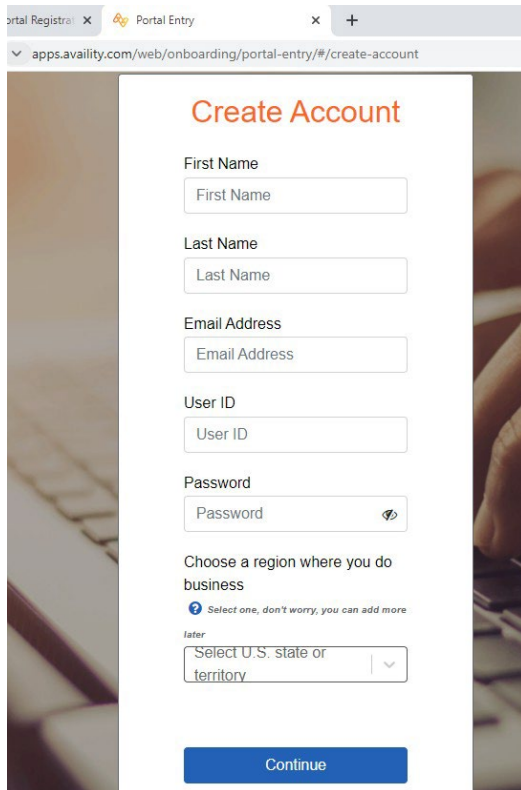


Locate your organization type below, then click the arrow to get started



Availity Provider Portal: Registration

Fill out all required fields and click Continue until you complete the registration process. At the end you will receive a notice like the one below ↓. Check your email and click the link provided to verify the account. Now you will need to Login and setup your 2-step authentication.



Portal Entry x +

apps.availity.com/web/onboarding/portal-entry/#/create-account

Create Account

First Name

Last Name

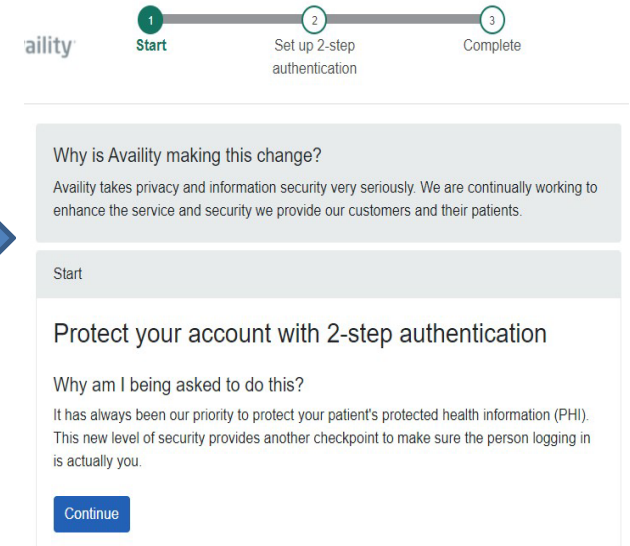
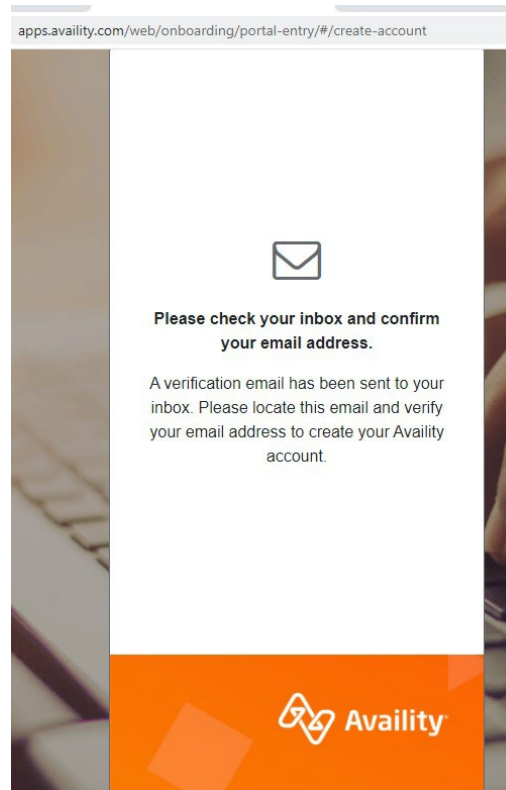
Email Address

User ID

Password

Choose a region where you do business
Select one, don't worry, you can add more later

[Continue](#)



1 Start 2 Set up 2-step authentication 3 Complete

Why is Availity making this change?
Availity takes privacy and information security very seriously. We are continually working to enhance the service and security we provide our customers and their patients.

Start

Protect your account with 2-step authentication

Why am I being asked to do this?
It has always been our priority to protect your patient's protected health information (PHI). This new level of security provides another checkpoint to make sure the person logging in is actually you.

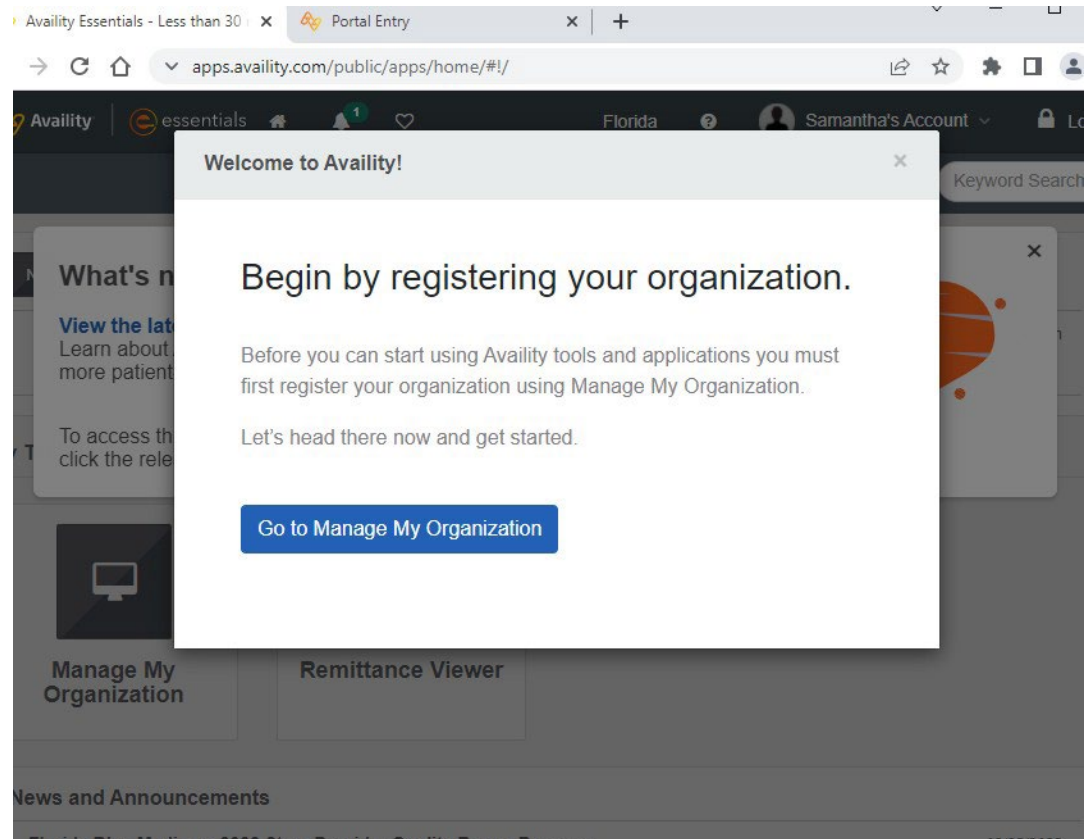
[Continue](#)

Note: For registration, login or technical issues please contact Availity Client Services at 1-800-282-4548

Availity Provider Portal: Welcome Page

In order to start using Availity tools and applications you must first register your organization.

Click the button and follow the prompts to complete the process.



Note: For registration, login or technical issues please contact Availity Client Services at 1-800-282-4548

Availity Provider Portal: Functions

Portal functions include:

- **Claim Status Inquiry**
- **Eligibility and Benefits**
- **Payer Space**
 - Claim submission Link (Through Connect center)
 - Contact Us Messaging for
 - Changing provider demographics
 - Claim Issues
 - Prior Auth/Auth issues
 - Member Eligibility Issues
 - HEDIS Record Submissions
 - Credentialing Inquires
 - Appeals and Grievances
 - Grievance Submission
 - Appeal Submission
 - Grievance a& Appeal Status check
- Panel Roster-Panel Look-Up
- Reports
 - PDM/ProReports (Provider Deliverables Manager)
 - Ambient (Business Intelligence Reporting)
- Prior Authorization Requirements Look Up
- **Prior Authorization**
 - Submission
 - Status

Note: For registration, login or technical issues please contact Availity Client Services at 1-800-282-4548

Claims Process: Overview

The claims process is a dense, complex, but no-less crucial component to the healthcare industry. The following slides will dive deeper into the individual facets of the process outlined below.

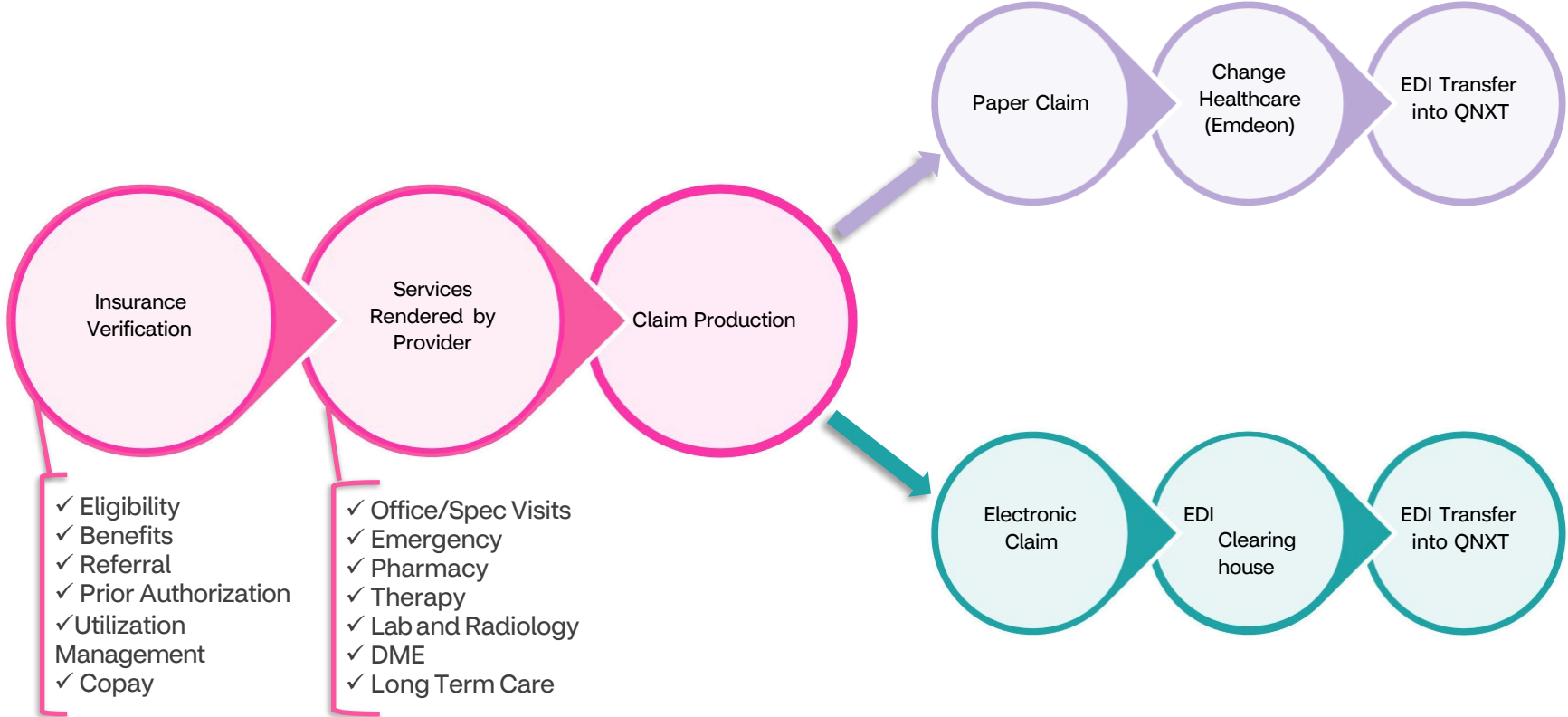
Life of a Claim



Phase 1

Claim Origination

Phase 1: Claim Origination Process OVERVIEW



Insurance Verification

Verifying Eligibility & Benefits

Eligibility: Presentation of an Aetna ID card is not a guarantee of eligibility. The Provider is responsible for verifying a member's current enrollment status before providing care.

Benefits: Benefits vary. Prior to rendering service, verify that the service is a covered benefit under the member's plan.

Member Eligibility and Benefits can be verified two ways:

Online

Through the Availity Web Portal at

<https://apps.availity.com/availity/web/public.elegant.login>

Telephone

Call the Member Services department at

1-800-441-5501

- ✓ **Eligibility**
- ✓ **Benefits**
- ✓ Referral
- ✓ Prior Authorization
- ✓ Utilization Management
- ✓ Copay

Insurance Verification

- ✓ Eligibility
- ✓ Benefits
- ✓ **Referral**
- ✓ Prior Authorization
- ✓ Utilization Management
- ✓ Copay

Referrals

Under certain member contracts, a referral must be obtained prior to the provision of certain covered services.

Specialist visits require a referral from the PCP with the exception of a few, noted below.

Referrals are accepted via script or can be executed using the referral form:

Referral Form

The form is located within the provider manual
[AetnaBetterHealth.com/
Florida/providers/provider
manual](https://www.aetna.com/betterhealth/florida/providers/provider_manual)

No referral is required for any care listed under the Direct Access provision of the provider manual. These include: Substance Abuse, Dermatology, Chiropractor, OB/GYN. Refer to provider manual for further details.

Insurance Verification

Prior Authorization

Under certain circumstances, a prior authorization must be obtained prior to rendering certain covered services.

Prior to submitting an auth request, use the **Check ABHFL Prior Auth Requirements** tool found as a link under the Resources tab in our Payer Space on Availity. This tool will help you determine if an authorization is needed.

- ✓ Eligibility
- ✓ Benefits
- ✓ Referral
- ✓ **Prior Authorization**
- ✓ Utilization Management
- ✓ Copay

Applications Resources News and Announcements Sort By A-Z

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

Filter By Category

<input type="checkbox"/> Community Resources (25)	♡ ABUSE Hotline	10/16/2020
<input checked="" type="checkbox"/> Provider Resources (12)	♡ American Heart Association	10/16/2020
<input type="checkbox"/> EFT/ERA (2)	♡ Beacon Health Options	10/16/2020
<input type="checkbox"/> Provider Documents (1)	♡ Centers for Medicare and Medicaid Services (CMS)	10/16/2020
	♡ Check ABHFL Prior Auth Requirements	01/16/2021
	♡ Find a Provider	08/12/2021

Insurance
Verification

Requesting Prior Authorization

Prior authorizations can be obtained two ways:

- ✓ Eligibility
- ✓ Benefits
- ✓ Referral
- ✓ **Prior Authorization**
- ✓ Utilization Management
- ✓ Copay

Online

Through the Availity Web Portal at

<https://apps.availity.com/availity/web/public.elegant.login>

Paper

Print the Prior Auth form online at

<https://www.aetnabetterhealth.com/florida/providers/provider-auth>

*Submit PA to the address indicated on the top of the printed form.

Authorization status can be obtained via the Availity portal or by calling 1-800-441-5501.

Insurance
Verification

Utilization Management

Utilization management (UM) is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department is composed of:

- ✓ Eligibility
- ✓ Benefits
- ✓ Referral
- ✓ Prior Authorization
- ✓ **Utilization Management**
- ✓ Copay

- Preauthorization
- Concurrent review
- Casemanagement

When the services are reviewed via our UM program, the medical director makes all final decisions regarding the denial of coverage for services.

If you have any questions or need to discuss a specific case, the UM staff is available at:

Program	Phone	Fax
Medicaid	1-800-441-5501	1-860-607-8056
Comprehensive LTC	1-844-645-7371	1-860-607-8726
Florida Healthy Kids	1-844-528-5815	1-844-404-5455

Insurance Verification

- ✓ Eligibility
- ✓ Benefits
- ✓ Referral
- ✓ Prior Authorization
- ✓ Utilization Management
- ✓ **Copay**

Copayments/Coinsurance/Deductible

- Most services covered by ABH carry a \$0 copay (refer to your provider manual and/or the member's ID card), however, there are instances where there is a member responsibility.
- ABH has no financial or other liability with respect to a member's failure to pay amounts due the providers for co-payment, co-insurance, or deductible as required under the member's contract or for non-covered services.

PLEASE NOTE: While it is best practice to collect member responsibility at the time of service, providers may not deny services to a recipient based solely on the recipient's inability to pay a copayment or coinsurance amount at the time services are rendered.

Providers may bill the recipient for the unpaid copayment or coinsurance amount.

Services Rendered by Provider

- ✓ Office/Special Visits
- ✓ Emergency
- ✓ Pharmacy
- ✓ Therapy
- ✓ Lab and Radiology
- ✓ DME
- ✓ Long Term Care

Rendering Service

Before you can produce a claim, you must have first rendered the service.

Aside from delivering quality care, one of the most **important** parts of providing service is making sure it is **documented completely and accurately**.

Without complete and accurate documentation, the next step (**Claim production**) will be difficult to complete.

Click here to visit the [Provider Manual](#) for a complete list of covered services and expanded benefits.

Click here for [Recordkeeping and Documentation Requirements](#) for providers rendering service to Florida Medicaid Recipients.

Preparing your Claim

Now that you have rendered service, it's time to file a claim.

One very important factor of an efficient billing process is the submission of **clean claims**.

A clean medical claim is one that has no mistakes and can be processed without additional information from the provider or a third party. It's correct from top to bottom.

The next few slides will provide you with the criteria and some tips for submitting clean claims.

Did you know?

Health insurance claims are most often rejected due to missing or inaccurate information, including patient name, subscriber information, and diagnosis and procedure codes.

Clean Claim Criteria

- The healthcare provider is licensed to practice on the date of service and is not under investigation for fraud. Provider must also have an active Medicaid provider ID.
- Every procedure code has a supporting diagnosis code, which eliminates any questions about medical necessity. In addition, the form includes no expired or deleted codes.
- The patient's coverage was in effect on the date of service, and the patient's insurance covers the service provided.
- The claim form includes all the required information (patient name, address, date of birth, identification number, and group number) in the correct fields.
- The form correctly identifies the payer and includes the right payer identification number and payer mailing address.
- The claim is submitted on time.

Use these links for further instructions
on how to fill out the different forms.



[How to Complete the UB-04](#)
[How to Complete the CMS
1500](#)

Validate Data before Submitting

Before you submit:

- ✓ Check Spelling and Accuracy of all fields.
- ✓ Don't forget your NPI: **Note:** Providers are required to submit their NPI on every claim. If you do not have one, you may apply for an NPI number by visiting the National Plan & Provider Enumeration Systems (NPPES) website: <https://nppes.cms.hhs.gov>
- ✓ Validate the CPT/HCPCS/ICD-10 codes against the documented services in the members record. **Remember your Modifiers and National Drug Codes (NDC) when required.**
- ✓ Remember to put your Authorization Information

Modifiers?

National Drug Codes (NDC)?



Helpful Information: Modifiers and NDC

Modifiers

A **modifier** is a code that provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code.

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Please refer to your CPT Manual for further detail on all modifier usage. There are also resources available online for reference.

National Drug Codes

The NDC, or **National Drug Code**, is a unique 10-digit, 3-segment number. It is a universal product identifier for human drugs in the United States. The code is present on all nonprescription (OTC) and prescription medication packages and inserts in the US.

For outpatient and physician-administered drugs, the following is required:

1. The applicable HCPCS or CPT code
2. Number of HCPCS/CPT units
3. NDC qualifier (N4)
4. NDC unit of measure (UN, ML, GR, F2)
5. Number of NDC units (up to three decimal places)

More on NDC 

Claim
Production

Helpful Information: More on NDC...

Example NDC



You must enter the NDC on your claim in an 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 configuration. See the examples below:

Label Configuration	Add leading zero, Remove hyphens
4-4-2 (xxxx-xxxx-xx)	0xxxxxxxxxx
5-3-2 (xxxxx-xxx-xx)	xxxxx0xxxxx
5-4-1 (xxxxx-xxxx-x)	xxxxxxxxx0x

[Click Here to Search the National Drug Code Directory](#)

NDC data in an **ELECTRONIC** claim

Here are general guidelines for including NDC data in **an electronic claim**:

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter N4 in this field	2410	LIN02
Product ID Qualifier	Enter the 11-digit NDC billing Format assigned to the drug administered	2410	LIN03
Product ID Qualifier	Enter the quantity (number of NDC units)	2410	CTP04
Product ID Qualifier	Enter the NDC unit of Measure for the prescription drug given (UN, ML, GR, or F2)	2410	CTP05

Note: The total charge amount for each line of service also must be included for the Monetary Amount in Loop ID, Segment SV102 for 839P and Segment SV203 for 837I.

NDC data on a Paper claim

Here are general guidelines for including NDC data on a **paper claim**:

CMS 1500: In the shaded portion of line-item field 24A-24G, enter NDC qualifier N4 (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units).

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.
From			To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER		\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
N400409476586 ML120																	
01	01	13	01	01	13	11		J0744				1	17.94	6	N	NPI	1234567891
																	123456789

UB-04: In line-item field 43, enter NDC qualifier N4 (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units).

42. Rev CD	43. Description	44. HCPCS/Rate	45. Serv. Date	46. Serv Units
636	N4[30126598741][UN][1111.234]	HCPC code	07/01/2018	HCPCS UNIT

11 DIGIT NDC

Unit of
Measure
Qualifier

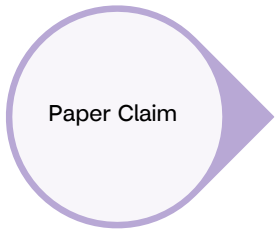
Unit Quantity

Submitting an **Electronic Claim**

ABH highly encourages electronic claim submission. 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.

- If you are registered with **Availity** you can submit claims electronically using this platform. Electronic claim submissions will be routed through Change Healthcare ConnectCenter who will review and validate the claims for HIPAA compliance and forward them directly to the Plan.
- **Providers can also submit directly to Change Healthcare .** Change Healthcare will provide the electronic requirements and set-up instructions. Providers should call 1-800-215-4730 or go to <https://physician.connectcenter.changehealthcare.com> for information on direct submission to Change Healthcare.

ABH claims payer ID for EDI: 128FL



Submitting a Paper Claim

Submit Paper Claims to:

Aetna Better Health of Florida
P.O. Box 982960
El Paso, TX 79998-2960

- Claims must be legible and suitable for imaging and microfilming for permanent record retention.
- Complete ALL required fields and include additional documentation when necessary.
- The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

Use this table to help you determine the correct claim form to be used.

Service	Claim Form
Medical and professional services	CMS 1500 Form
Hospital inpatient, outpatient, skilled nursing and emergency room services	CMS UB-04 Form
Dental services that are considered medical services (oral surgery, anesthesiology)	CMS 1500 Form

Timely Filing Guidelines

Claims will be denied when they are submitted past the timely filing deadline. Unless otherwise stated in the Provider agreement, the following guidelines apply.

Provider / Claim Type	Timely Filing Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within 180 days after the date of service or discharge from an inpatient admission.
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within 365 days after the date of service or discharge from an inpatient admission.
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within ninety (90) calendar days after the final determination of the primary payer.
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within 36 months of the original submission to Medicare.
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within 180 days from the date of service or discharge from an inpatient admission.
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within thirty-five (35) days after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents.

Corrected or Voided Claims- Important Information

Claims need to contain the correct billing code to help us identify when a claim is being submitted to **correct or void** a claim that we've previously processed.

If the provider handwrites, stamps, or types "Corrected Claim" on the claim form without entering the appropriate Frequency Code (7 or 8) along with the Original Reference Number, the claim will be considered a first-time claim submission.

Corrected or Voided Claims

When processing a Corrected or Voided Claim, a Payment Reversal may be generated which may produce a negative amount, which will be seen on a later Remittance Advice than the Remittance Advice that is sent for the newly submitted corrected claim.

Corrected claims should be submitted with ALL line items completed for that specific claim, and they should never be filed with just the line items that need to be corrected.

Submitting Corrected or Voided Claims – via Paper

Provider must include the original Aetna Better Health of Florida claim number and bill frequency code (7 for corrected, 8 for void) per billing standards.

Institutional Claims Example:

Box 4 – Type of Bill: the third character represents the “Frequency Code”:

3a. PAT. CNTL. #				4. TYPE OF BILL
b. MED. REC. #				117
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM	7. THROUGH		

Box 64 – Place the Claim number of the Prior Claim in Box 64:

64. DOCUMENT CONTROL NUMBER
1234E567891

Professional Claimsexample:

Box 22 – Enter the appropriate bill frequency code (7 or 8) left adjusted in the left side of box and the original claim number on the right side.

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	1234E567891

Submitting Corrected or Voided Claims – **Electronically**

To submit a Corrected or Voided Claim electronically:

Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating to replace '7' or void '8'

Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)

Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim to be replaced.)

Coordination of Benefits (COB)

Members may have more than one insurance plan. When this happens, the two insurance plans work together to pay claims for the same person. This process is called **coordination of benefits**.

In the event that ABH is the secondary payer, COB claims must be submitted within ninety (90) days after final determination by the primary payer.

All explanations of payment or denials from the member's primary carrier must be submitted with the claim and should be sent to:

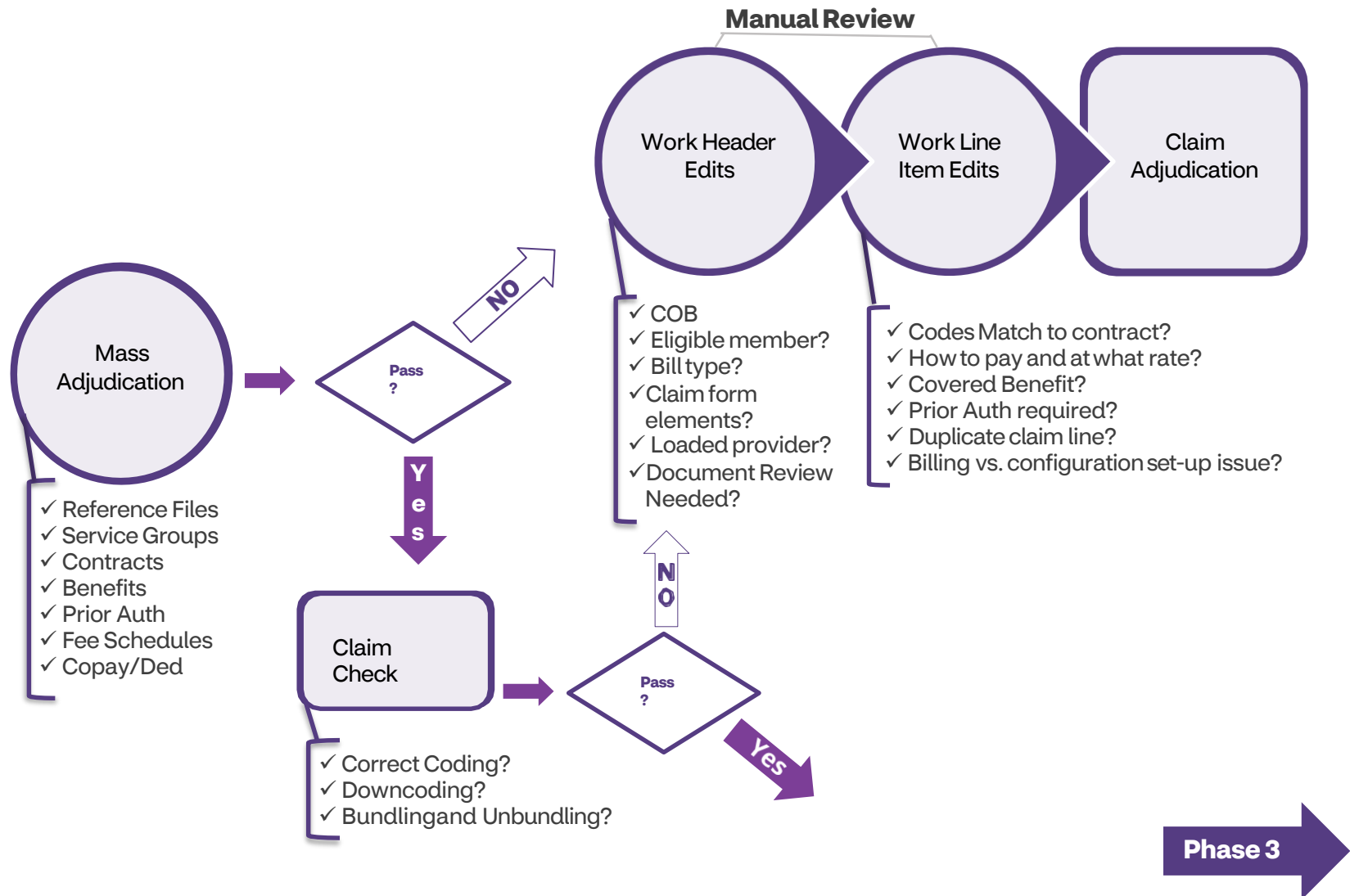
Aetna Better Health of Florida
P.O.Box 982960
El Paso, TX 79998-2960

NOTE: If Medicare is the primary payer, claims will automatically crossover to the plan once Medicare has processed it and made a determination.

Phase 2

Claim Adjudication

Phase 2: Claim Adjudication Process OVERVIEW



Mass Adjudication

- ✓ Reference Files
- ✓ Service Groups
- ✓ Contracts
- ✓ Benefits
- ✓ Prior Auth
- ✓ Fee Schedules
- ✓ Copay/Ded

Mass Adjudication

The Claim Adjudication process is a function of the plan. There are many parties within the health plan that are involved but we will walk through a high-level overview.

Once a claim has been entered into our system, it goes through Mass Adjudication. During Mass adjudication claim information is bumped up against contracts, benefits, authorization requirements, fee schedules, etc.

There are two outcomes. It either **passes** or **fails**.

If it passes, it goes through a process that checks for correct coding, downcoding, unbundling, etc. and then on to Phase 3 for Final Status.

If the claim does NOT pass mass adjudication or does not pass through the claim check process, it is pended for manual review by one of our claims specialist.

Manual Review



If claims do not pass mass adjudication or do not pass the claim check process that follows, EDITS are assigned to the claim and they are **PENDED FOR MANUAL REVIEW**.

Depending on the EDIT, it will be reviewed by a claims team representative and/or a clinical representative who are responsible for manually reviewing and thoroughly researching these pended claims in order to assure proper processing.

Once a claim has been reviewed and a determination has been made as to how it should process, it is sent back to the claims team for processing.

Common Pend Reasons		
Coordination of Benefits?	Document Review Needed?	Duplicate claim line?
Eligible member?	Codes Match to contract?	Billing vs. configuration set-up issue?
Bill type?	How to pay and at what rate?	Loaded provider?
Claim form elements?	Covered Benefit?	Prior Auth required?

EDITS

EDITS are logic within the claims processing system that evaluates information on the claims and depending on the evaluation, takes action on the claims, such as pay in full, pay in part, or pend for manual review.

ABH periodically updates its policies and claims payment systems to be aligned with correct-coding initiatives, as well as these national benchmarks and industry standards:

- Centers for Medicare & Medicaid Services (CMS) guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®)
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 9th Edition (ICD-9) and 10th Edition (ICD-10)

We deny, completely or in part, claims submitted without required information or with invalid information.

Note: Claims processed after the implementation date, regardless of date of service, will process according to the most recent version. No retrospective claim payment changes are made for processing changes that are a result of new editing rules.

Visit [CMS-Medicaid.gov](https://www.cms-medicaid.gov) for more information on the CMS National Correct Coding Initiative.

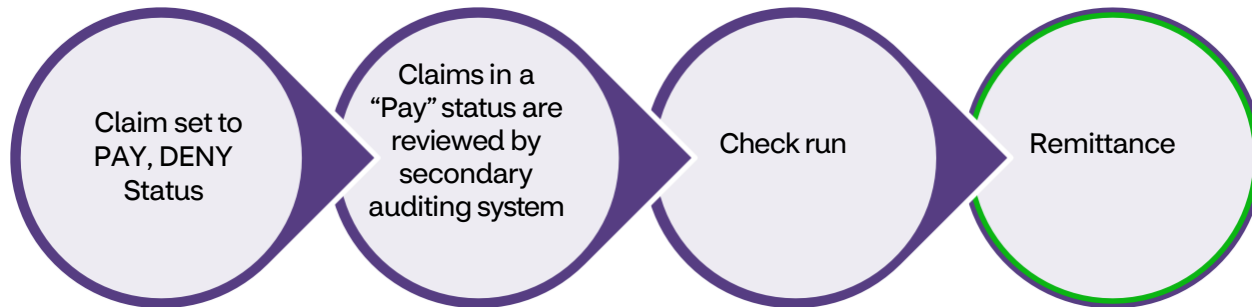
Common EDITS

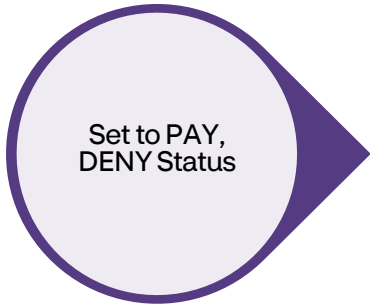
Code	Description
M62	Missing/incomplete/invalid treatment authorization code.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing
29	The time limit for filing has expired
146	Diagnosis was invalid for the date(s) of service reported
18	Exact duplicate claim/service
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
M86	Service denied because payment already made for same/similar procedure within set time frame.
96	Non-covered charge(s)
M119	Missing/incomplete/invalid/ deactivated/ withdrawn national drug code (NDC).
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
252	An attachment/other documentation is required to adjudicate this claim/service
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor
N390	This service cannot be billed separately.

Phase 3

Post Adjudication

Phase 3: Post Adjudication Process OVERVIEW





Claim Status

During the stage 3 of the claim life cycle the claim is given one of two statuses:

PAY	This is a claim status in QNXT prior to the paid date. This term specifically means that the claim has passed the adjudication process and is ready to be submitted for payment.
DENY	This is a claim status in QNXT prior to the paid date. This term specifically means that the claim has either failed adjudication or has been pended for manual review and is not ready to be submitted for payment.

Claims in a **PAY** status will be run through a secondary auditing system before payment is released.

Claims with a **DENY** status have failed adjudication and will be sent back to the provider with an explanation of denial or have been pended for further manual review.

Claims in a
“Pay” status are
reviewed by
secondary
auditing system

Secondary Auditing System

Before payment is released, claims are audited one last time to assure compliance with:

- Applicable state and federal regulations
- timely filing guidelines
- coding combinations
- Maximum units
- place of service
- other editing guidelines

Check run

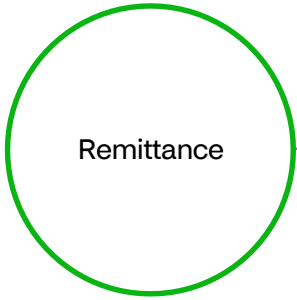
Check Run

After auditing is complete the claim is released for payment and/or final denial.

Aetna Better Health of Florida generates checks **weekly**.

Providers can receive payment directly to their bank account or via paper check.

We encourage our providers to take advantage of electronic funds transfers (EFT) as it shortens the turnaround time for you to receive payment.



Remittance

The Provider Remittance Advice (remit) is the final step of Phase 3 and serves as notification to the provider of the claims processed during the payment cycle. Claims processed during a payment cycle will appear on a “remit” as paid, denied, or reversed.

Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claims by EFT. You must also have the ability to receive ERA through an 835 file.

A separate remit is provided for each line of business in which the provider participates.

Note: Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued.

Signing up for ERA / EFT

ERA

Electronic remittance advice is an electronic file that contains claim payment and remittance information sent to your office. This is sometimes referred to by its HIPAA transaction number, 835.

EFT

Electronic fund transfer Electronic fund transfer offers electronic payments deposited directly into providers' bank accounts.

Enrollment

To enroll in EFT/ERA Registration Services (EERS) visit Change Health payer enrollment services website <https://payerenrollservices.com/>.

Change Healthcare Support Team can be contacted at 800-956-5190 Monday through Friday 8:00am to 5:00pm CST.

Please contact our Provider Relations department for additional questions or assistance with this process.

Frequently Asked Questions

Has your information changed?

Please notify the Plan in writing within sixty (60) days or in accordance with your agreement of any additions, deletions or changes to the topics listed below. Our phone number is **1-800-441-5501** or **1-800-645-7371** or you can fax us at **1-844-235-1340**. See mailing address below.

Failure to notify the Plan timely could negatively impact claims processing.

- Tax identification number (submission of W-9 required). Changing a tax identification number will require a new agreement with the new tax identification number
- Office or billing address
- Telephone or fax number
- Specialty (may require additional credentialing)
- New physician additions to the practice (please allow time for credentialing)
- Licensure (DEA, state licensure or malpractice insurance)
- Group affiliation
- Hospital privileges

Aetna Better Health of Florida
Attn: Network Operations Department
8200 NW 41st Street, Suite 125
Doral, FL 33166

Payment Rates / Fee Schedule

Your contract will outline the specific fee schedule methodology used to determine your payment rates.

The Plan updates all Medicaid based fee schedules as published by Medicaid and in accordance with Medicaid effective dates assigned to codes and reimbursement. Upon publication of codes previously not valued by Medicaid, the Plan will update Medicaid-based schedules accordingly.

The Plan will request code specific discrepancy reports be pulled; claims will be reviewed and over and underpayments will be handled accordingly with providers. The Plan will reprocess any provider claims affected by new codes upon provider's written request.

Notifications regarding Billing/Coding update

Visit our website or the Availity Provider Portal to view **Notifications** related to Billing/Coding and other helpful information.

The screenshot displays the Aetna Better Health of Florida website. The navigation menu includes 'Home', 'Become A Member', 'For Members', 'For Providers', 'Health & Wellness', and 'Availity'. The 'For Providers' menu is highlighted with a red box. Below it, a sub-menu lists 'For Providers', 'Join Our Network', 'Provider Manual', 'Notifications And Newsletters' (highlighted with a red box), 'Authorizations', 'Document Library', 'Pharmacy', 'Practice Guidelines', and 'Provider Education'. The main content area is titled 'Notifications and Newsletters' and contains a list of provider notifications. The 'News and Announcements' tab is highlighted with a red box. Below the tabs, a disclaimer states: 'THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!'. A table lists the following items:

Item	Date
AMA- Provider Portal Update!	11/29/2021
Provider Notifications and Newsletters	08/25/2020

High Dollar Claims

All claims submitted to the Plan with an **expected payable amount** of over \$50,000 (“high dollar”) require the accompaniment of an itemized statement.

High dollar claims not accompanied by itemization are subject to denial.

If a hospital provider receives such a denial, the claim should be marked as a resubmission and resubmitted with the itemization for processing.

The purpose of the itemization review is to identify items billed under routine services in an inpatient setting that are not separately billable.

Anesthesia Billing Guidelines

When billing anesthesia services be sure to submit claims with the total anesthesia service time. Time is reported in total minutes, not units.

Every 15-minute increment is considered 1 unit. During claims processing, the total time is divided by 15-minute increments and rounded down to the nearest whole unit. Total time that is less than 15 minutes is rounded up to 1 unit and will also pay base rate.

Remember to include the appropriate modifiers. Claims billed without the required modifiers will be denied.

REQUIRED MODIFIERS			
Billing Information	Modifier	Description	Reimbursement
Modifier Information Billed by an Anesthesiologist	AA	Anesthesia services personally performed by the anesthesiologist	
	AD	Supervision, more than four procedures	
	QK	Medical Direction of two, three or four concurrent anesthesia procedures	50% of Base Fee, Medicaid Allowable
	QY	Medical Direction of one CRNA by an anesthesiologist	50% of Base Fee, Medicaid Allowable
Modifier Information Billed by a CRNA or Anesthesiology Assistant	QX	Anesthesia, CRNA or Anesthesiology Assistant, medically directed	50% of Base Fee, Medicaid Allowable
	QZ	Certified Registered Nurse Anesthetists (CRNA) without medical direction by a physician	80% of Base Fee, Medicaid Allowable

AS APPROPRIATE MODIFIERS	
Modifier	Description
QS	Monitored anesthesiology care services
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care (MAC) for patient who has history of severe cardiopulmonary condition
78	Unplanned return to the operating room, related procedure

Note: According to Aetna Policy, anesthesia is considered incidental when billed with certain pain management codes. Charges for anesthesia will be denied as incidental. Visit our [Provider Notices and Newsletters](#) page for more information.

Balance Billing

- Providers shall accept payment from Aetna Better Health of Florida for Covered Services provided to our Members in accordance with the reimbursement terms outlined in the Agreement.
- Payment made to providers constitutes payment in full, with the exception of Member Expenses.
- For Covered Services, providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement.
- An adjustment in payment as a result of Aetna Better Health of Florida's claims policies and/or procedures does not indicate that the service provided is a non Covered Service, and Members are to be held harmless for Covered Services.
- For more information on balance billing, refer to the Florida Statutes 641.3154 and 641.3155 (5)a.(8).
- Additionally, Providers shall not charge Members for missed appointments.

Vaccine for children program

Florida Medicaid providers must be registered with the Vaccines for Children (VFC) program. The VFC is administered by the Department of Health, Bureau of Immunizations.

This program supplies providers with vaccines for children 0-18 years of age at no charge to physicians and eliminates the need to refer children to County Health Departments (CHDs) for immunizations.

Aetna Better Health of Florida (ABHF) covers the administrative fee for these vaccines. **In order for providers to get reimbursed for the administration of these vaccines they must bill the vaccine itself with a modifier of “SL” and the applicable administrative service code.**

Additional information regarding ordering VFC program vaccines is available on the Florida SHOTS website at <http://flshotsusers.com>. VFC Resources are available on the following link: <http://flshotsusers.com/training/training-guides>.

Who pays?

	MMA	FHK	MediKids
Immunizations	VFC	Aetna	Aetna (as of 2017)
Administration	Aetna	Aetna	Aetna

**For more information please contact your Network
Relations Consultant or a Provider Services
Representative.**

Thank you.

