Aetna Better Health of Florida

Monthly Claims Training- April

Denise E. Castro

aetna®

April 29, 2021

Learning objectives

As part of your Aetna Better Health of Florida's monthly claims training, we will

- Discuss Billing Guidance for:
  - Covid-19 Vaccine
  - Bacterial Urine Cultural
  - Tobacco Cessation
- Review Global Obstetric Policy-Multiple Deliveries
- Review Anesthesia Billing Modifiers
- Discuss Change Healthcare Web Connect Tool
- Introduce Availity- New Provider Web Portal
- Explain Timely Filling Guidelines
- Inform the importance of EFT/ERA Registration

COVID-19 Vaccines

Billing Guidance- Covid-19 Vaccine Administration

Effective 3/15/2021, Florida Medicaid providers administering COVID-19 vaccines to Florida Medicaid recipients are required to submit claims with the specific vaccine product Current Procedural Terminology (CPT), its corresponding National Drug Code (NDC) and the specific vaccine product administration CPT code in order to receive reimbursement for administration.

If the administration code is billed without the vaccine code, the claim will be denied and a corrected claim will need to be submitted.

The vaccine product should be billed with an amount of $0.00 as the vaccine product is not reimbursable.

COVID-19 VACCINE ADMINISTRATION CODES

Procedure Code	Description	Age
0001A	Pfizer-Biontech COVID-19 Vaccine Administration – First Dose	16 years and older
0002A	Pfizer-Biontech COVID-19 Vaccine Administration – Second Dose	16 years and older
0011A	Moderna COVID-19 Vaccine Administration – First Dose	18 years and older
0012A	Moderna COVID-19 Vaccine Administration – Second Dose	18 years and older
0031A	Johnson and Johnson COVID-19 Vaccine Administration	18 years and older

COVID-19 VACCINE PRODUCT CODES

Procedure Code	NDC	Description	Labeler Name
91300	59267100001 59267100002 59267100003	SARSCOV2 VAC 30 MCG/0.3ML IM	Pfizer
91301	80777027310 80777027399	SARSCOV2 VAC 100 MCG/0.5ML IM	Moderna
91303	59676058005	SARSCOV2 VAC AD26 .5ML IM	Johnson & Johnson (Janssen)

Bacterial Urine Culture

Bacterial Urine Culture Billing

A bacterial urine culture is a laboratory procedure performed on a urine specimen to establish the probable etiology of a presumed urinary tract infection. This is not to be confused with CPT codes 81000-81005 which are used to describe Urinalysis testing.

Dx Code	Description
87086	Culture, bacterial; quantitative, colony count, urine.
87088	Culture, bacterial; with isolation and presumptive identification of each isolates, urine.

According to our policy, which is based on CMS Policy, in order to be reimbursed for CPT 87086, appropriate ICD-10 codes must be used. The ICD codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage of CPT 87086. For a full list of appropriate codes to be billed with CPT 87086 and 87088, please visit https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10

Dx Code	Description
N30.00	Acute cystitis without hematuria
N30.01	Acute cystitis with hematuria
N39.0	Urinary tract infection, site not specified
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms
R10.9	Unspecified abdominal pain
R30.0	Dysuria
R30.9	Painful micturition, unspecified
R31.0	Gross hematuria
R31.29	Other microscopic hematuria
R31.9	Hematuria, unspecified
R32	Unspecified urinary incontinence
R35.0	Frequency of micturition
R39.15	Urgency of urination
R39.9	Unspecified symptoms and signs involving the genitourinary system
R53.83	Other fatigue
R73.03	Prediabetes
R80.9	Proteinuria, unspecified
R82.90	Unspecified abnormal findings in urine
R82.998	Other abnormal findings in urine
Z79.899	Other long term (current) drug therapy

Tobacco Cessation

Billing Guidance-Tobacco Cessation

CPT codes 99406 and 99407 are used to report counseling, by a physician or non-physician practitioner, for smoking and tobacco use cessation counseling.

Code	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intermediate, greater than 10 minutes

OBs and Midwives billing 99406/99407

- These codes are for actual counseling, not just screening for tobacco use
- The claims must include a diagnosis from the charts shown on the next few slides
- Modifier 25 should be appended to the E/M code to indicate separate services

PCPs billing 99406/99407

- Routine office visit with counseling – Modifier 25 should be appended to the E/M code to indicate separate services
- Preventative visit with counseling – 99406 and 99407 are not payable. Counseling is considered part of the preventative visit.
    - Note: Providers may bill a preventative visit and an E/M visit together using Modifier 25 on the E/M code if there is a specific problem/issue that they addressed during the preventative visit, however, the counseling is not payable

Billing Guidance-Tobacco Cessation – Cont'd

Diagnosis Codes allowed for 99406/99407:

When billing for these services providers must use an ICD-10 F17 code or a Z code. The F codes are used if the patient is dependent on tobacco. The Z codes are used if there is not dependence on tobacco. The Z codes cannot be combined with an F17 code.

Aetna Better Health of Florida also reimburses for tobacco cessation counseling provided to pregnant women. The codes specific to maternal and newborn health (O99) and the toxic effects of tobacco (T65) are used by medical providers to reflect the biological impact of tobacco use.

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
F17.200*	Product unspecified, uncomplicated
F17.201*	Product unspecified, in remission
F17.203	Product unspecified, with withdrawal
F17.208	Product unspecified, with other nicotine-induced disorders
F17.209	Product unspecified, with unspecified nicotine-induced disorders
F17.210*	Cigarettes, uncomplicated
F17.211*	Cigarettes, in remission
F17.213	Cigarettes, with withdrawal
F17.218	Cigarettes, with other nicotine-induced disorders
F17.219	Cigarettes, with unspecified nicotine-induced disorders
F17.220*	Chewing tobacco, uncomplicated
F17.221*	Chewing tobacco, in remission
F17.223	Chewing tobacco, with withdrawal

Billing Guidance-Tobacco Cessation – Cont'd

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
F17.228	Chewing tobacco, with other nicotine-induced disorders
F17.229	Chewing tobacco, with unspecified nicotine-induced disorders
F17.290*	Other tobacco product, uncomplicated
F17.291*	Other tobacco product, in remission
F17.293	Other tobacco product, with withdrawal
F17.298	Other tobacco product, with other nicotine-induced disorders
F17.299	Other tobacco product, with unspecified nicotine-induced disorders
Z57.31	Occupational exposure to environmental tobacco smoke • May not be used with Z77.22 exposure to environmental smoke
Z77.22	Contact with and suspected exposure to environmental smoke • May not be used with a F17.2 tobacco dependence or Z72 tobacco use code.
Z71.6	Counseling and Medicaid Advice – tobacco abuse counseling
Z72.0	Problems Related to Lifestyle and tobacco use not otherwise specified
Z87.891	Personal history of nicotine dependence • May not be used with F17.2 current nicotine dependence code.
Z13.89	Encounter for screening for other disorder. Use for tobacco use screening.

Maternal Tobacco Use and Newborn Exposure- add an additional F17 code to indicate type of tobacco

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
O99.330	Smoking (tobacco) complicating pregnancy, unspecified trimester
O99.331	Smoking (tobacco) complicating pregnancy, first trimester
O99.332	Smoking (tobacco) complicating pregnancy, second trimester
O99.333	Smoking (tobacco) complicating pregnancy, third trimester
O99.334	Smoking (tobacco) complicating childbirth
O99.335	Smoking (tobacco) complicating puerperium
P04.2	Newborn suspected to be affected by exposure in utero to tobacco smoke • May not be used with P96.81 newborn exposure to environmental tobacco smoke.
P96.81	Exposure to (parental) (environmental) tobacco smoke in the perinatal period

Global Obstetric Policy-Multiple Deliveries

Global Obstetric Policy-Multiple Deliveries

Due to recent claim discrepancies regarding Global Obstetric-Multiple Deliveries, ABHFL has updated the Global Obstetric Policy for Multiple Deliveries which became effective on November 1st, 2020.

The purpose of this policy is to define that if more than one delivery code (**59400-59410, 59414, 59510-59515 or 59610-59622**) has been billed within a six-month period by any provider or specialty, then the subsequent delivery codes will be denied.

It is not expected that more than one obstetrical delivery service would occur in less than a six-month time frame.

aetna®

Global Obstetric Policy-Multiple Deliveries

The following OB Services and coding guidelines are defined by the AMA.

- **Delivery Services Only**: Per the CPT book, "Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery." The following are the CPT defined delivery only codes: 59409, 59514, 59612, and 59620. The delivery only codes should be reported by the Same Group Physician and/or Other Health Care Professional for a single gestation when:

    - The total OB package is not provided to the patient by the same single physician or group practice and itemization of services needs to occur

    - Only the delivery component of the maternity care is provided, and the postpartum care is performed by another physician or group of physicians

- **Duplicate Obstetrical Services:** Duplicate OB services are defined as any of the below listed CPT codes provided by the same or different physician on the same or different date of service. This follows the coding guidelines defined by the AMA. CPT codes for global OB care fall into one of three categories:

    - Single component codes (for example, delivery only)
    - Two component codes (for example, delivery including postpartum care)
    - Three-component, or complete, global codes (including antepartum care, delivery, and postpartum care)

  The codes are as follows: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, and 59622.

- **Delivery Only including Postpartum Care:** Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both of these services. The following are CPT defined delivery plus postpartum care codes: 59410, 59515, and 59622

Global Obstetric Policy-Multiple Deliveries

The delivery only including postpartum care codes should be reported by the Same Group Physician and/or Other Health Care Professional for a single gestation when:

- The delivery and postpartum care services are the only services provided
- The delivery and postpartum care services are provided in addition to a limited amount of antepartum care (e.g., CPT code 59425).

The following services are included in delivery only including postpartum care code and are not separately reimbursable services:

- Hospital visits related to the delivery during the delivery confinement
- Uncomplicated outpatient visits related to the pregnancy
- Discussion of contraception
- 59410 is used for delivery and postpartum care
- 59430 is used for postpartum care only

aetna®

Anesthesia Billing Modifiers

Anesthesia Billing Modifiers

Services that involve administration of anesthesia should be reported by the use of the Current Procedural Terminology (CPT) anesthesia five-digit procedure codes, American Society of Anesthesiologists (ASA) or CPT surgical codes plus a modifier.

Aetna Better Health of Florida will require that appropriate anesthesia modifier be filed on anesthesia services. Each provider should use the appropriate modifier.

An anesthesiologist, CRNA or Anesthesiology Assistant (AA) can provide anesthesia services. The anesthesiologist, CRNA or AA can bill separately for anesthesia services personally performed. When an anesthesiologist provides medical direction to a CRNA or AA, both the anesthesiologist and the CRNA/AA should bill for the appropriate component of the procedure performed.

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

aetna

Change Healthcare Web Connect Tool

Web Connect Tool

We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health.

Within the next month, ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims, all at no cost to you. Get started TODAY!

You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until 5/31/2021.

You will be able to setup a new account in just seconds. Once you have received your new credentials, you may immediately begin checking eligibility.

Claim submission will be available to you within one business day of setting up your account. Be sure to bookmark the new login page: https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214558

Link: https://physician.connectcenter.changehealthcare.com/#/register/step1/PQCGR5mGCwgELkrDndrXQaA6NIakfqyNVLp3Qt-1Q-sI6IP6mLTz8Qf_jaeJUM9-

aetna

Availity

Availity Provider Portal- Live 1/19/2021

Current Functionalities

- ✓ Payer Spaces
- ✓ Claim Submission Links (CHC)
- ✓ Contact Us messaging
- ✓ Claim Status Inquiry
- ✓ Appeal & Grievance Submissions
- ✓ Reports (Ambient)
- ✓ Prior Authorization – Submission and Status Lookup

Future Functionality Releases

Q2 2021
- Eligibility and Benefits

Q3 2021
- Remit PDF
- Enhanced Panel Roster
- Enhanced G&A Tool

Our communications will be transitioning from fax blast to via email in the near future. Keeping our providers informed is our priority. If you have not yet reached out to us to ensure we have your most recent email address, we ask that you do so now!

How to submit your most updated email address to us?

It's simple, just follow one of these steps:

1. Complete the following survey monkey: https://www.surveymonkey.com/r/W8QDMS7
2. Send us an Email at: FLMedicaidProviderRelations@Aetna.com
    - Your email subject line should include the title and + NPI #. Example (Email Address Update + 12345678).

Be on the lookout over the next few months for co-branded emails directly from Availity as new products roll out and training plans are developed.

aetna

Timely Filling Guidelines

Timely Filing Requirements

Providers should submit timely, complete, and accurate claims to the Aetna Better Health of Florida. Untimely 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	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. (F.S. 641.3155)
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. (SMMC Contract) (Section VIII.D)(E)(2)
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. (SMMC Contract) (Section VIII)(E)(1)(h)
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. (SMMC Contract) (Section VIII)(E)(2)(d)(2)
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. (F.S. 641.3155)
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. (F.S. 641.3155(2)(c)(2)

aetna

EFT/ERA Registration

EFT and ERA Registration

Aetna Better Health provider portal has moved into the Availity system effective January 2021.

Providers will be taken to our health plan website where the EFT and ERA forms are housed when clicking on the EFT and ERA applications.

Why should Providers Register?

- Save time and money with these electronic tools
- Electronic remittance advice (ERA) provides claims payment explanations in HIPM· compliant files.
- Electronic funds transfer (EFT) puts payment right into your account.
- Explanations of Benefits (EOBs) are on our secure provider website. Patient cost estimator is available on our provider portal on Availity.

We highly encourage providers to register for EFT and ERA. Please call our Provider Services Department at 1-844-528-5815 for assistance or your assigned Network Consultant.

aetna

Questions? We've got answers.

Just call our Provider Services Department at 1-844-528-5815 .

aetna®