Aetna Better Health® of Illinois
PO Box 818031, MC F661
Cleveland, OH 44181-8031

December 8, 2023

Aetna Better Health® of Illinois

Notice of new Medicaid claims and encounters front end edits

Illinois Healthcare and Family Services (HFS) is required by the United States Code of Federal 42 CFR § 438 Subpart H to verify that all providers, provider groups and affiliations who wish to provide services to Medicaid participants have their enrollment verified. This requirement applies to contracted Managed Care Organizations (MCOs), as well [aligns to rules 438.6 (b)(1) and 438.6(b)(2)]. HFS requires contracted MCOs to verify that all providers, provider groups and their affiliates who wish to provide services to Medicaid participants have their active enrollment on the date of service be verified prior to claim adjudication.

Aetna Better Health® of Illinois has revised our clean claim edits to ensure compliance with the State of Illinois HFS rules and edits. Aetna Better Health of Illinois will begin enforcement of these revised edits as of January 31, 2024. This letter is being sent to ensure your medical office is also preparing to ensure compliance. Together, we can reduce the impact and disruption to billing operations.

The clean claim edits will reject EDI claims and deny Paper claims when a unique and effective Medicaid ID cannot be found on the State of Illinois HFS registry for any of the following provider categories:

Professional Claims - 837P or CMS-1500	**Institutional Claims - 837I or UB04**
Billing Provider 2010AA/Box 33A	Billing Provider 2010AA or Box 56
Rendering Provider 2310B/2420A or Box 24J	Rendering Loop 2310D/2420C or Box 79 with 82 Qualifier
Referring Provider 2310A/2420F or Box 17B with DN Qualifier	Referring Loop 2310F/2420D or Box 79 with DN Qualifier
Ordering/Prescribing Provider 2420E or Box 17B with DK Qualifier	N/A
Supervising Provider 2310D/2420D or Box 17B with DQ Qualifier	N/A
N/A	Attending Provider 2310A or Box 76
N/A	Operating Loop 2310B/2420A or Box 77
N/A	Other Operating Loop 2310C/ 2420B or Box 78 with ZZ Qualifier

Providers are responsible for resolving any State registration issues and are not permitted to balance bill the Medicaid subscriber.

Providers of Aetna Better Health® of Illinois Medicaid patients must be registered with the State of Illinois's registry, using their National Provider Identifier (NPI), Taxonomy Code, Provider Type, Practice address and Billing address. Registration must occur prior to rendering services to the plan's membership. Atypical providers are not required to have a National Provider ID (NPI). The Health Plan will perform edits based on the Medicaid ID submitted using the G2 qualifier in the rendering and/or billing loops.

As of January 31, 2024, providers will be required to submit claims with the Billing and/or Rendering, Provider Taxonomy codes that are consistent with the registered specialty and services being rendered. We will reject EDI Claims and deny paper claims if the taxonomy code is not submitted for either the Billing or Rendering NPI. We strongly encourage sending the taxonomy codes associated to the Referring and Attending Provider types when included on the claim.

Please follow the billing guidelines outlined in:

- **wpc-edi.com** when submitting EDI 837I/837P Claims
- **nucc.org** when submitting Professional CMS-1500 Claim Forms
- **nubc.org** when submitting Institutional UB-04 Claim Forms

The following pages provide some **general taxonomy** billing guidance based on the sources cited above.

EDI submitters

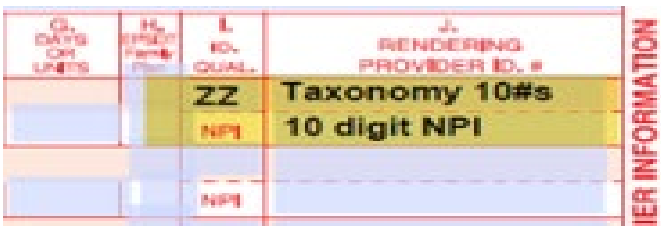
We are requiring taxonomy submissions in:

- Professional Claim: Loop AND Segment 2310B-PRV or Loop and Segment 2000A-PRV, send both when Billing and Rendering are different.
- Institutional Claim: Loop and Segment 2000A-PRV

Paper CMS-1500 (v02-12) forms

We will require Taxonomy Codes in either Box 24J Shaded area or Box 33.

Rendering Provider Taxonomy: Box 24 J Shaded Area



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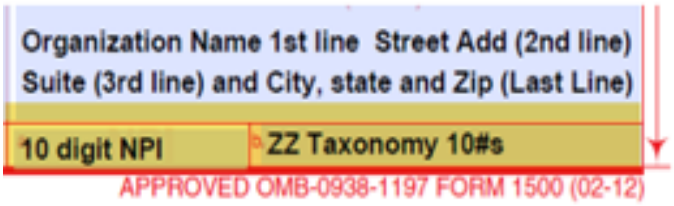
Billing Provider Taxonomy: Box 33B

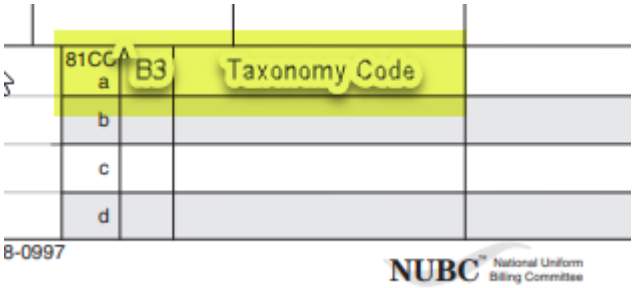


In addition, we highly encourage Taxonomy be submitted in **Box 17a** with the "ZZ" qualifier when submitting Referring Provider information as seen below.

Referring Provider Taxonomy: Box 17a

Paper UB-04 forms

We will require Taxonomy Codes in **Box 81** is the "B3" qualifier as seen below.



In addition, we highly encourage Taxonomy be submitted in **Box 76** with the "ZZ" qualifier when submitting Attending Provider information as seen below.

For each rejected or denied claim, Aetna Better Health® of Illinois will send remittance with the appropriate corresponding CARC/RARC Codes and Descriptions based on the edit that is applied to the claim. Please refer to the table below for edit remittance details.

If you have any questions about our claim submission process, please call our Aetna Better Health® of Illinois Claims Inquiry/Claims Research (CICR) Department at **1-866-329-4701**.

Thank you,

Provider Relations
Aetna Better Health of Illinois®
AetnaBetterHealth.com/Illinois-Medicaid

Remittance edit table

EDIT DESCRIPTION	CARC CODE & DESCRIPTION	RARC CODE & DESCRIPTION	277CA 2200D STC
Taxonomy Required for Billing NPI	16: Claim/service lacks information or has submission/billing error(s)	N255: Missing/incomplete/invalid billing provider taxonomy.	STC01-1 = A3 = "Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system" STC01-2 = 145 = "Entity's specialty/taxonomy code" STC01-3 = 85 = "Billing Provider"
Taxonomy Required for Rendering NPI	16: Claim/service lacks information or has submission/billing error(s)	N288: Missing/incomplete/invalid rendering provider taxonomy.	STC01-1 = A3 = "Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system" STC01-2 = 145 = "Entity's specialty/taxonomy code" STC01-3 = 82 = "Rendering Provider"
Invalid, Missing or Inactive Billing Provider NPI	16: Claim/service lacks information or has submission/billing error(s) 299: The billing provider is not eligible to receive payment for the service billed	N257: Missing/incomplete/invalid billing provider/supplier primary identifier. N767: The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	2200D STC01: • STC01-1 Industry Code = "A7" = Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. • STC01-2 Industry Code = "21" = Missing or invalid information. • STC01-3 = "85" = "Billing Provider" 2200D STC10: • STC10-1 = "A7" • STC10-2 = "132" = Entity's Medicaid ID • STC10-3 = "PR"

Invalid, Missing or Inactive Rendering Provider NPI	16: Claim/service lacks information or has submission/billing error(s) 185: The rendering provider is not eligible to perform the service billed	N290: Missing/incomplete/invalid rendering provider primary identifier. N767: The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	2200D STC01: • STC01-1 Industry Code = "A7" = Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. • STC01-2 Industry Code = "21" = Missing or invalid information. • STC01-3 = "82" = "Rendering Provider" 2200D STC10: • STC10-1 = "A7" • STC10-2 = "132" = Entity's Medicaid ID • STC10-3 = "PR"
Invalid, Missing or Inactive Attending Provider NPI	16: Claim/service lacks information or has submission/billing error(s) 208: National Provider Identifier - Not matched. 283: Attending provider is not eligible to provide direction of care.	N253: Missing/incomplete/invalid attending provider primary identifier. N767: The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed	2200D STC01: • STC01-1 Industry Code = "A7" = Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. • STC01-2 Industry Code = "21" = Missing or invalid information. • STC01-3 = "71" = "Attending Provider" 2200D STC10: • STC10-1 = "A7" • STC10-2 = "132" = Entity's Medicaid ID • STC10-3 = "PR"
Performing Provider ID Number (Atypical Provider) is not on file.	16: Claim/service lacks information or has submission/billing error(s) B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N257: Missing/incomplete/invalid billing provider/supplier primary identifier. N767: The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	2200D STC01: • STC01-1 Industry Code = "A7" = Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. • STC01-2 Industry Code = "21" = Missing or invalid information. • STC01-3 = "85" = "Billing Provider" 2200D STC10: • STC10-1 = "A7" • STC10-2 = "132" = Entity's Medicaid ID • STC10-3 = "PR"