Billing and Administrative Gap Closure Guidelines

The preferred method of gap closure for VBS and HEDIS data capture is administrative capture via claims submissions with complete coding. Aside from VBS and HEDIS, the Pay for Quality Program is also exclusively driven by administrative capture. Please refer to the following guidelines.

Initial Submission

Initial claims submissions must occur within 180 days after services were rendered.

Be sure to fully code on any initial claim submission to ensure complete capture of care and gap closure. Fully code for the services you provide in block 24d of the CMS 1500 Claim Form. Codes from the following code sets can be used on claims:

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).
  - Diagnosis codes – entered on block 21 of CMS 1500 Claim Form.
- Place of service codes (POS).
  - Can include inpatient hospitals, nursing facilities, hospices etc. These are generally two digits long.
- Healthcare Common Procedure Coding System (HCPCS) Level II Codes.
  - These describe supplies, services, products.
- Current Procedural Terminology (CPT) Codes.
  - These identify and categorize services and medical procedures.

Resubmitted Claims

Aetna Better Health must receive claims resubmission no later than 365 calendar days from the date of the provider remittance advice or explanation of benefits if the initial submission was within the 180 calendar day time period whether or not the initial claim was denied. If the provider performed the services, they can submit claims to capture care that was not previously reflected on original claim submission by:

- Submit an adjustment to the original claim, being sure to include ALL previously submitted services codes (with appropriate bill amount), and adding in the new service lines with appropriate dollar amounts for services rendered.
  - Resubmitted codes are entered in block 22 of the CMS 1500 Claim Form.
  - For electronic resubmissions, providers must submit a frequency code of 7.
  - For paper resubmissions, use the original rejected ICN in Block 22 of the CMS-1500 Claim Form. A frequency code of 7 must also be on the resubmitted claim.
  - For resubmitted UB claims the bill type will need to be an XX7.
- In order to improve your HEDIS scores and receive Pay for Quality Payments, resubmitted claims must be submitted to the plan by January 31st of the next calendar year.

Submitting Claims for Lab Data

If you perform in house labs always fully code to capture both the test and the result. This is especially important for the HbA1c portion of the Comprehensive Diabetes Care (CDC) HEDIS measure as a result is needed for gap closure.

If you order the lab and the member has the lab drawn at an outside lab you may submit a claim with zero dollar amount billed, with only a CPT II code indicating the lab result. The date you enter on this claim submission will correspond with the date of collection by the lab. All other claim elements need to be present (diagnosis, NPI, units, etc.) on the claim you are submitting for the lab result.

- This claim may come back rejected or denied. This will not affect data capture for HEDIS purposes.

Billing for Well-Care when member is sick

Capturing preventive care services for the following HEDIS measures:

- Child and Adolescent Well Visits (WCV)
- Well Child Care in the first 30 months of life (W30)
  - Must capture 6 or more visits for members turning 15 months in the measurement year. The visits should occur between birth through 15 months of age.
  - Must capture 2 or more visits for members turning 30 months in the measurement year. The visits should occur between the ages of 15-30 months.

Use the following tips to capture preventive services when an acute condition, illness or abnormality is discovered, or a preexisting problem is also present. The acute issue also requires a problem-oriented evaluation and management (E/M) service that includes history, physical examination, and medical decision-making, counseling/care coordination or a combination of these.

- Use the appropriate office or other outpatient service code (99201–99215) in addition to the preventive medicine service code. Append modifier 25 to the office or other outpatient service code. Use the modifier 25 when:
  - A separate condition was treated along with the well child check.
  - Labs, radiology, or other diagnostic procedures or services were ordered to indicate a separate condition was treated along with the well child check
  - There were supplies or equipment billed that are unrelated to the well child check
- Example — A patient presents for a sprained ankle and the physician orders ankle x-rays. On the EMR health maintenance, an alert indicates the patient is due for their well visit. Both the acute issue and well child check can be treated as long as the documentation supports an E&M.
  - A 99213 with modifier 25 is reported in addition to 99392 appropriately.

Federally Qualified Health Center (FQHC) Billing Guidelines

It is recommended that FQHCs bill the CPT-HCPCS itemization in addition to the T1015 clinic code

- Not itemizing services on claims results in record requests.
- The T1015 clinic visit code does not describe the services actually performed.
  - Example — Well Care Checks: To administratively capture care for the WCV or W30 measures any of the following codes would need itemized on the claim: 99381-99385

The CICR team can assist you with claim related questions and concerns. The CICR staff is available to assist 8:00 a.m.–5:00 p.m. Monday–Friday. Just call **1-866-638-1232**. You can also reach the Provider Relations Department for assistance by phone **1-866-638-1232**.

If you are unable to reach your representative by phone, please reach out to the Provider Relations Department email for additional assistance - ABHProviderRelationsMailbox@Aetna.com.

Alternate methods of gap closure

Data File Transfer

A newer method of gaps closure would be data file transfer via Excel templates. Sharing data on templates will eliminate the need to go to the medical record to pull data. The following steps must be completed prior to data transfer:

- The provider will need to complete the Quality Data and Clinical Integration Questionnaire. Data sharing can be customizable with each group based on provider response.
- Initial meeting with the provider group and Aetna Better Health to review questionnaire and identify optimal data sharing method and template layout is to occur.
- The provider group and Aetna Better Health will meet monthly until data sharing has been established.

** Please note — data sharing is considered a supplemental data source based on NCQA HEDIS specifications and will require additional steps for auditor approval and validity.*

For inquiries related to data file transfer, please reach out to Aetna Better Health of Pennsylvania's Quality Management Department at AetnaBetterHealthPAQM@Aetna.com.