



Aetna Better Health® of Virginia

New Aetna Better Health Claims and Encounters Front End Edits

The Virginia Department of Medical Assistance Services (DMAS) is required by the United States Code of Federal Regulations *42 CFR § 438 Subpart H* to verify that all providers who wish to provide services to Medicaid members have their enrollment verified. This requirement applies to contracted managed care organizations (MCOs) and aligns to rules *438.6 (b)(1) and 438.6(b)(2)*. In Virginia, contracted MCOs are required to verify that all providers who wish to provide services to Medicaid members have their Medicaid Enterprise System (MES) enrollment completed and verified using the state's Provider Service Solution (PRSS) Portal before rendering services to Medicaid members.

Aetna Better Health has prepared clean claim edits to ensure compliance with the DMAS rules and edits. Aetna Better Health will begin enforcing these edits as of July 1, 2023. Together, we can reduce the impact and disruption to billing operations. The clean claim edits will deny claims when an effective Medicaid ID cannot be found on the MES 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 member.

Registration with MES

Providers of Aetna Better Health members must be registered with the MES using their National Provider Identifier (NPI), taxonomy code practice address and billing address. Registration must occur prior to rendering services to Medicaid members. Atypical providers are not required to have an NPI. Aetna Better Health will perform edits based on the Medicaid ID submitted using the G2 qualifier in the rendering and/or billing loops.

Enrollment in PRSS Portal

In April 2022, DMAS launched a new portal to manage provider enrollment, the PRSS Portal. Medicaid providers must use the PRSS Portal, located on the MES website at virginia.hppcloud.com, to complete enrollment. All Medicaid managed care network providers must enroll through the PRSS Portal to satisfy and comply with federal requirements of the *21st Century Cures Act*.

On the PRSS Portal, select “Enroll as a new provider or check your enrollment status.” Only one enrollment application is necessary in the PRSS Portal, even if a provider participates with more than one MCO. Once approved, providers must create a PRSS Portal account to revalidate their enrollment, make changes to personal or business information, and check member eligibility. You can find helpful training resources on the MES website at vamedicaid.dmas.virginia.gov/provider.

Note: Those network providers currently enrolled as fee-for-service in Medicaid do not need to reenroll in PRSS.

As of **July 1, 2023**, providers are required to submit claims with the billing and/or rendering, provider taxonomy codes consistent with the registered specialty and services being rendered. Aetna Better Health will reject the claim if the taxonomy code is not submitted for either the billing or rendering NPI. Aetna Better Health strongly encourages sending the taxonomy codes associated to the referring and attending provider types when included on the claim.

Follow the billing guidelines outlined in the resources below:

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

The following page provides some **general taxonomy** billing guidance based on the sources cited above.

EDI Submitters

- Aetna Better Health is 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

- Aetna Better health will require Taxonomy Codes in either Box 24J Shaded area or Box 33

Rendering Provider Taxonomy: Box 24 J Shaded Area

CL. DAYS ON UNITS	HL. SPECIALTY	IL. ID. QUAL.	JL. RENDERING PROVIDER ID. #	CLER INFORMATION
		ZZ	Taxonomy 10#s	
		NPI	10 digit NPI	
		NPI		

Billing Provider Taxonomy: Box 33B

Organization Name 1st line	Street Add (2nd line)
Suite (3rd line) and City, state and Zip (Last Line)	
10 digit NPI	ZZ Taxonomy 10#s

APPROVED OMB-0938-1197 FORM 1500 (02-12)

- In addition, Aetna Better Health highly encourages Taxonomy be submitted in **Box 17a** with the “ZZ” qualifier when submitting Referring Provider information as seen below.

Referring Provider Taxonomy: Box 17a

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. ZZ	Taxonomy 10#s
DN	Referring Prov LName, FName	17b. NPI	10 digit NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Paper UB-04 Forms

- Aetna Better health will require Taxonomy Codes in **Box 81** is the “B3” qualifier as seen below.

81CCA	a	B3	Taxonomy Code
	b		
	c		
	d		

B-0997 NUBC National Uniform Billing Committee

- In addition, Aetna Better Health highly encourages Taxonomy be submitted in **Box 76** with the “ZZ” qualifier when submitting Attending Provider information as seen below.

76 ATTENDING	NPI	QUAL	ZZ	Taxonomy Code
LAST		FIRST		

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

Remittance Edit Table

Edit Description	CARC Code and 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"

Edit Description	CARC Code and Description	RARC Code & Description	277CA 2200D STC
Invalid, Missing or Inactive Attending Provider NPI	<p>16: Claim/service lacks information or has submission/billing error(s)</p> <p>208: National Provider Identifier - Not matched.</p> <p>283: Attending provider is not eligible to provide direction of care.</p>	<p>N253: Missing/incomplete/invalid attending provider primary identifier.</p> <p>N767: The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed</p>	<p>2200D STC01:</p> <ul style="list-style-type: none"> • 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" <p>2200D STC10:</p> <ul style="list-style-type: none"> • STC10-1 = "A7" • STC10-2 = "132" = Entity's Medicaid ID • STC10-3 = "PR"
Performing Provider ID Number (Atypical Provider) is not on file.	<p>16: Claim/service lacks information or has submission/billing error(s)</p> <p>B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.</p>	<p>N257: Missing/incomplete/invalid billing provider/supplier primary identifier.</p> <p>N767: The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.</p>	<p>2200D STC01:</p> <ul style="list-style-type: none"> • 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" <p>2200D STC10:</p> <ul style="list-style-type: none"> • STC10-1 = "A7" • STC10-2 = "132" = Entity's Medicaid ID • STC10-3 = "PR"

Questions?

If you have any questions about our claim submission process, contact our Claims Inquiry/Claims Research (CICR) Department by calling **1-800-279-1878**.

Provider Relations
Aetna Better Health of Virginia