DISCLOSURE OF CLEAN CLAIM ELEMENTS; DISCLOSURE OF NECESSARY ATTACHMENTS; DISCLOSURE OF ADDITIONAL CLEAN CLAIM ELEMENTS; DISCLOSURE OF REVISION OF DATA ELEMENTS, ATTACHMENTS OR ADDITIONAL CLEAN CLAIM ELEMENTS; DISCLOSURE OF PROCESSING PROCEDURES; DISCLOSURE OF TIMEFRAME FOR CLAIM FILING

Clean Claim Definition: A clean claim is a claim that contains the information that Aetna requires and is submitted consistent with Aetna’s established processing procedures, to the extent Aetna establishes the information and processing procedure requirements consistent with the Texas Claims Regulations (28 TAC sec. 21.2801 et seq.).

The procedures for members with a primary care physician associated with an IPA may differ. IPA association is generally identifiable on the member’s HMO ID card or may be verified by contacting Aetna Member Services.

The Texas Claims Regulations identify minimum requirements. They also allow Aetna to modify, add or drop data elements, clean claim elements, and attachments, and allow Aetna to specify processing procedures for submitting claims. Aetna’s Clean Claim Disclosure Statements as amended from time to time for HCFA 1500 and UB92 forms more fully describe Aetna’s clean claim requirements and processing procedures.

Aetna Required Data Elements, Clean Claim Elements, and Attachments

A clean claim submitted on paper or on its electronic equivalent must be on a HCFA 1500 form and must include all information and attachments listed. A claim will not be a clean claim if it is missing any of the information or attachments below, and the statutory period for payment (usually 45 days from Aetna’s receipt of a claim) will not apply. These requirements will go into effect on June 1, 2003.

- Box 1a – Patient or Member Plan ID Number
- Box 2 - Patient Name
- Box 3 – Patient Date of Birth and Gender
- Box 4 – Subscriber’s Name
- Box 5 – Patient’s Address (street or P.O. Box, city, zip)
- Box 6 – Patient’s relationship to Subscriber
- Box 7 – Subscriber’s Address (street or P.O. Box, city, zip)
- Box 8 – Patient Status
- Box 9 – COB Information

Aetna requires the billing entity to attach an Explanation of Benefits form from the additional payer.

- Box 9D – Other Insurance Company Name
- Box 10A – Injury Code
- Box 10B and C – Accident Indicator
- Box 11 – Subscriber’s Policy Group Number
- Box 11A – Subscriber’s Birth Date and Gender
- Box 11C – HMO or PPO Carrier Name
- Box 11D – Other Insurance Indicator
- Box 13 – Assignment on File
- Box 14 – First Symptom / Onset Date

This field is required when the emergency indicator is ‘Y’ (Box 23I).
This is the date of first symptoms of illness or injury. It may be either prior to or on the current date of service. Box 15 – If Patient has had same or similar illness, give first date. Box 17 – Referring Physician Name. Box 18 – Inpatient Admit Date. Required for inpatient claims. Must be a valid date and may not be greater than the current billing date. Box 21 – ICD 9 Codes. Box 24A – Date of Service. This field must meet standard date edit and must not be greater than the current date. Box 24B - Place of Service Code. Box 24 C – Type of Service. Box 24D – CPT Codes(s), any Appropriate Modifiers and Anesthesia Time (in minutes). Box 24E – Diagnosis Code by Specific Service.

Remarks - (No Box Available): The Remarks field is designed for use in those limited situations where Aetna requires supplementary data, that is, data in addition to the information entered in the Boxes identified above. Note: The electronic definition of this field is established by vendors and may vary.

In order for a claim to be a clean claim the following additional documents are required.

Modifiers
There are situations in which a claim must be submitted using a CPT modifier. The use of modifiers can indicate an unusual event occurred or that the procedure or service was altered in some way.

When billing with certain CPT modifiers you must provide a complete description of the service performed including supporting documentation such as operative report, or anesthesia notes. Relevant information should include adequate description of the nature and events that occurred during the procedure or at the time of service.

Modifier-22 Unusual Procedural Service
Submit complete description of the procedure including operative report

Modifier-23 Unusual Anesthesia
Submit complete description of the procedure including operative report and anesthesia notes
All Unlisted/Unspecified Codes
Include a complete written description of the procedure and written report for all unlisted/unspecified
codes. See the requirements below for the following specific codes.

All Unlisted Anesthesia Codes
For example: CPT 01999-Unlisted anesthesia procedure
Submit complete description of the procedure including operative report

All Unlisted Surgical Procedures
For example: CPT 19499-Unlisted procedure, breast
Submit complete description of the procedure including operative report

All Unlisted Radiology/Imaging Procedures
For example: CPT 78799-Unlisted genitourinary procedure, diagnostic nuclear medicine
Submit complete description of the procedure including imaging report

All Unlisted Laboratory Procedures
For example: CPT 84999-Unlisted chemistry procedure
Submit complete description of the procedure including report

All Unlisted Medical Procedures & Supplies
For example: CPT 93799-Unlisted cardiovascular service or procedure; CPT 99070-Supplies and
materials (except spectacles), provided by the physician over and above those usually included
with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
Submit complete description of procedure including office notes and report.

All Unclassified Drug Codes
For example: HCPCS J3490-Unlisted drugs
State the NDC code, name of drug, manufacturer's name, dose, number of doses and number of
doses administered.
Submit complete description of the service including itemized invoice

All Other Unlisted, Non-specific HCPCS Codes
For example: HCPCS A0999-Unlisted ambulance service
HCPCS E1399-Durable medical equipment, miscellaneous
HCPCS A4649-Surgical supply, miscellaneous
Submit complete description of the service, including itemized invoice

All Non-specific ICD-9 Codes
For Example: ICD-9 799.8-ILL-Define condition nec
ICD-9 794.9-ABN Function study nec
Submit complete description of the diagnosis including office notes and history & physical

Coordination of Benefits (COB): If indicating "yes" to COB in Box 9 the other carrier's allowed and
payment amount must be included or attached to the claim. Aetna requires an Explanation of Benefits
form from the other payer.

Precertification: If the claim is for an urgent or emergent health care service that requires
precertification, and the physician, practitioner, or member did not obtain precertification, then the
physician or practitioner must do the following:

- Attach data to support the clinical information requirements for coverage found in the Coverage
Policy Bulletins section located at www.aetna.com. If the website address is not available, call
Aetna’s customer service department, using the phone number on the member’s ID card, to obtain the Coverage Policy Bulletin requirements for coverage.

If precertification was not required for the member’s plan and was not obtained, Aetna requires data that supports the clinical information requirements for coverage found in the Coverage Policy Bulletins located at www.aetna.com for the procedure performed. This requirement applies to the procedures and services listed below.

1. Inpatient confinements:
   - Surgical and non-surgical confinements
   - Skilled nursing facility
   - Rehabilitation facility
   - Inpatient hospice (except Medicare)
   - Maternity confinements (for notification purposes only please call after the first prenatal visit)

2. Reconstructive procedures and procedures that may be considered cosmetic:
   - Blepharoplasty/canthopexy/canthoplasty
   - Excision of excessive skin due to weight loss
   - Tattoo removal, revision or application
   - Rhinoplasty/rhytidectomy
   - Gastroplasty/gastric bypass
   - Pectus excavatum repair
   - Breast reconstruction/breast enlargement
   - Breast reduction/mammoplasty
   - Surgical treatment of gynecomastia
   - Lipectomy or excess fat removal
   - Treatment of penile dysfunction
   - Sclerotherapy or surgery for varicose veins
   - Any other potentially cosmetic procedure

3. Selected durable medical equipment:
   - Electric or motorized wheelchairs and scooters
   - Clinitron and electric beds
   - Limb and torso prosthetics
   - Customized braces

4. Medical Injectables:
   - Intravenous immunoglobulin (IVIG)
   - Growth hormone
   - Rebi®
   - Blood clotting factors
   - Remicade®
   - Pegasys®

5. Uvulopalatopharyngoplasty including laser-assisted procedures
6. Orthognathic surgery procedures, osteotomies and surgical management of the temporomandibular joint
7. Laparoscopic infertility surgery
8. Bunionectomy and hammertoe surgery
9. Elective (non-emergent) transportation by ambulance, or medical van and all transfers via air ambulance
10. All home health care services
11. Requests for in-network level of benefits for nonparticipating physicians and providers for non-emergent services
12. Dental implants and oral appliances
13. Services that may be considered investigational or experimental
14. National Medical Excellence Program® for all major organ transplant evaluations and transplants including but not limited to kidney, liver, heart, lung and pancreas and bone marrow replacement or stem cell transfer after high dose chemotherapy
15. HMO plan members only: Outpatient imaging precertification for CTs MRI/MRA, Nuclear Cardiology, Pet Scans: Call MedSolutions at 1-888-693-3211.

Optional Fields: Optional fields are any boxes on the HCFA 1500 form that are not required to be filled as specified above. It is strongly recommended that these fields be entered on the claim in order to expedite claim processing.

Timeframe in Which To File a Claim
In order to be considered for payment, a claim must be filed within 95 days of the final date of service, unless a different contract provision exists.