



Texas Physicians, Practitioners and  
Other Professional Providers  
Claims Submitted Using HCFA 1500  
Forms  
March 28, 2003

**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 identifies 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	Aetna requires the billing entity to attach an Explanation of Benefits form from the additional payor.
Box 2 - Patient Name	Box 9D – Other Insurance Company Name
Box 3 – Patient Date of Birth and Gender	Box 10A – Injury Code
Box 4 – Subscriber's Name	Box 10B and C – Accident Indicator
Box 5 – Patient's Address (street or P.O. Box, city, zip)	Box 11 – Subscriber's Policy Group Number
Box 6 – Patient's relationship to Subscriber	Box 11A – Subscriber's Birth Date and Gender
Box 7 – Subscriber's Address (street or P.O. Box, city, zip)	Box 11C – HMO or PPO Carrier Name
Box 8 – Patient Status	Box 11D – Other Insurance Indicator
Box 9 – COB Information	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 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  
Box 24F – Charges for Each Listed Service  
Box 24G – Number of Days or Units  
Box 24J – COB Information. Allowed and paid amounts required.  
Box 24K – Reserved for Local Use  
Box 25 – Tax ID Number (TIN)  
Box 28 – Total Charge  
Box 29 – Amount Other Carrier of Member Paid  
Box 30 – Balance Due  
Box 31 - Provider's Name/Signature  
Box 32 – Facility where Services Rendered  
Box 33 – Provider Billing Name, Address, Phone Number and Identification Number

**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.

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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 payor.

**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](http://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.

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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](http://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
- Rebif®
- 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.