Aetna Better Health® of Michigan

28588 Northwestern Hwy, Suite 380B
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NEW POLICY UPDATES

CLINICAL PAYMENT, CODING AND POLICY CHANGES

We regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see the below chart of upcoming new policies.

Effective for dates of service beginning November 1, 2023:

CMS Coverage Policies- Unauthorized COVID-19 Monoclonal Antibodies, Vaccines, and Related Administration- According to our policy, which is based on CMS Policy and the Food and Drug Administration (FDA), certain monoclonal antibodies used to treat COVID-19 are not authorized in the United States for the reported date of service.
Device and Supply Policy- Pass-Through and Non-Pass Through Drugs and Biologicals Require an OPPS-Payable Procedure- According to our Policy, which is based on CMS Policy, when a pass-through or non-pass-through drug other than a radiopharmaceutical is billed, a payable OPPS procedure must be submitted for the same date of service
Evaluation and Management Services Policy- -Transitional Care Management (TCM) Services- According to our policy, which is based on AMA CPT Manual and CMS Policy, Transitional Care Management services are required to be reported within 14 days after discharge from a facility. -Interprofessional Telephone/Internet Consultations- According to our policy, which is based on the AMA CPT Manual and HCPCS Level II Manual, Telephone Evaluation and Management services should not be reported within seven (7) day period, same day, or on the previous day of a related Evaluation and Management service.

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Diagnosis Code Guideline Policy-

-Factors Influencing Health Status and Contact with Health Services Diagnoses and Non-Routine Examinations-According to the ICD Manual guidelines, diagnosis codes indicating “immunization not carried out and under immunization status” and “persons encountering health services for specific procedures and treatment, not carried out” indicate that the procedure was not carried out and therefore, is not eligible for reimbursement.

-Gestational Diabetes Coding-According to our policy, which is based on the ICD-10-CM Official Guidelines for Coding and Reporting, diagnoses indicating long term use of insulin, hypoglycemic drugs or non-insulin antidiabetic drugs should not be assigned with codes for diabetes mellitus in pregnancy, childbirth, and the puerperium.

Diagnosis Validity Policy-

-Diagnosis Specificity- According to our policy, which is based on CMS Policy, CPT and HCPCS codes should be accompanied by valid ICD codes that are coded to the highest level of specificity.

-Invalid Diagnosis Codes-According to our policy, which is based on CMS Policy, CPT and HCPCS codes should be accompanied by valid ICD codes that are coded to the highest level of specificity.

Modifier Policy-COVID CS Modifier- According to our policy, which is based on CMS policy, effective May 12, 2023, CMS no longer accepts modifier CS (COST SHARE WAIVER COVID-19) as a valid modifier for services submitted.

Radiology Policy- Diagnostic Imaging - 3D Rendering- According to our policy, which is based on CMS policy, 3D rendering with interpretation and reporting of CT, MRI, US, or other tomographic modality, requires an appropriate diagnosis when reported with transthoracic echocardiography (TTE). A qualifying procedure for the

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3D rendering should also be included on the same date of service, or in the previous three days.