Aetna Better Health® Kids
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Aetna Better Health® Kids
A CHIP Health Plan

OCTOBER 18, 2023

CLINICAL PAYMENT, CODING AND POLICY CHANGES

NEW POLICY UPDATES – EFFECTIVE JANUARY 1, 2024

We regularly revise our clinical, payment and coding policy positions as part of our ongoing policy review processes. This notice is developed to keep you informed of the details of the upcoming new policies or policy changes for Aetna Better Health Kids (CHIP).

Please see the information below regarding upcoming new policies which are effective January 1, 2024.

POLICY	DETAILS
Device and Supply Policy – Pass-Through and Non-Pass-Through Drugs and Biologicals Require an OPPS-Payable Procedure	Our policy, based on CMS Policy and I/OCE Specifications, drug and biological codes billed with pass-through status or non-pass-through status must be reported with an OPPS payable procedure on the same date of service to be eligible for reimbursement. Furthermore, radiopharmaceuticals require that the payable OPPS procedure be reported on the same claim.
Diagnosis Code Policy – Health Services for Specific Procedures and Treatment – Not Carried Out	Our policy, based on ICD-10-CM Official Guidelines for Coding and Reporting, diagnosis indicating that the patient decided not to carry out procedure and treatment, will not be eligible for reimbursement.
Diagnosis Code Policy – Insulin Use	Our policy, based on ICD-10-CM Official Guidelines for Coding and Reporting, diagnoses indicating long term 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-Invalid Diagnosis Codes	Our policy, based on CMS Policy, CPT and HCPCS codes should be accompanied by valid ICD codes that are coded to the highest level of specificity.
Evaluation and Management Services – Interprofessional Telephone/Internet Consultations	Our policy, based on the AMA CPT Manual and HCPCS Level II Manual, telephone Evaluation and Management services, remote evaluation of recorded video and/or image, or brief check in by MD/QHP should not be reported if an E/M service has been billed on the same day, previous seven days, or following day with the same primary diagnosis.

Evaluation and Management Services – Transitional Care Management (TCM) Services	Our policy, based on the AMA CPT Manual, TCM Services are to be reported within the required code definition time frame from the date of discharge for members undergoing a transition from a facility level of service to a community setting.
Radiology Policy- Diagnostic Imaging - 3D Rendering	Our policy, 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 3D rendering should also be included on the same date of service, or in the previous three days.

Please note: This new process may result in a change in how your practice is reimbursed for these services. We urge you to thoroughly review the information in this notice.

Questions? Call Provider Relations at 1-866-638-1232 for assistance.