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FAX

To: All Aetna Better Health of Louisiana Providers
Effective: 1/1/2018

Attention: 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 (1/1/2018).**

Diagnosis Code Guidelines - ICD10 Laterality: One of the unique attributes to the ICD-10-CM code set is that laterality has been built into code descriptions. Some ICD-10-CM codes specify whether the condition occurs on the left or right, or is bilateral. The CPT code modifier should be consistent with the ICD and line level diagnoses should not be conflicting
Diagnosis - Age Consistency-Maternity Diagnoses: According to the ICD manual certain diagnosis codes have been identified as being specific to certain age groups. We would not expect to see procedures with maternity diagnoses for a member that is not of maternity age.
Cardiology - Duplex Scan for Carotid Artery Stenosis (CAS) in Asymptomatic Adult Patients: According to the U.S. Preventive Services Task Force, it is not appropriate to screen for carotid artery disease in asymptomatic adult patients. When a duplex scan of extracranial arteries is reported, a diagnosis indicating a supporting symptom should be reported.
Cardiology - E/M Services with Implantable Cardiac Device Monitoring: According to CMS policy, Evaluation and Management (E/M) services are not separately payable when performed on the same date of service as implantable cardiac device monitoring services or acoustic cardiography services unless the E/M service is a significant, separately identifiable service.

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Bundled Facility Payment Policy - Pre-Admission Outpatient Services Treated as Inpatient Services (3-Day Window Payment Policy): According to CMS policy, outpatient services provided on either the date of inpatient admission or during the three calendar days immediately preceding the date of inpatient admission are included in the Inpatient Prospective Payment System (IPPS) payment when provided by the same admitting hospital. This includes preadmission diagnostic services, nondiagnostic services and all other services with the exception of ambulance.
Bundled Facility Payment Policy - Outpatient Services Treated as Inpatient Services: According to CMS policy, services provided by an outpatient hospital during an inpatient admission are not separately billable as they are included in the inpatient facility payment.
Bundled Services Policy - Packaged and Conditionally Packaged Laboratory Services: According to CMS policy, laboratory services (except for molecular pathology), are considered packaged services under the Outpatient Prospective Payment System (OPPS). However, packaged laboratory services reported as the only services performed, or reported with clinically unrelated services, are considered separately payable.
CMS National Coverage Determinations (NCD) Policy - Clinical Diagnostic Laboratory Services (General Policy): CMS has identified a list of diagnosis codes that are considered never covered for clinical diagnostic laboratory services. Laboratory services will be expected to be reported with a supporting diagnosis.
Duplicate Services Policy - Duplicate Claims From Same National Provider Identifier (NPI) Under Any Tax ID and Provider ID: The National Provider Identifier (NPI) is a unique identification number for health care providers. A duplicate claim is a claim or claim line that has been previously submitted for payment with the same NPI (among other criteria). Only one claim would be expected to be reported for the same date of service and same NPI, regardless of Tax ID or Provider ID.
Laboratory-Pathology Policy - Natriuretic peptide-According to CMS Regional Carriers: BNP is useful in establishing or excluding the diagnosis and assessing the severity of CHF in patients with acute dyspnea. This test is also used to predict the long-term risk of cardiac events or death across the spectrum of acute coronary syndromes when measured in the first few days

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after an acute coronary event. As a diagnostic test, BNP testing is not expected to be performed more than four times in a given year
Modifier Policy - Anatomical Modifiers-According to the AMA CPT Manual, the HCPCS Level II Manual and our policy, the anatomic-specific modifiers, such as fingers, toes and coronary designate the area or part of the body on which the procedure is performed. It is correct coding to append modifiers to the greatest specificity at all times.
Neurology Policy - Ambulatory or 24-hour EEG Monitoring: According to CMS policy, ambulatory or 24-hour EEG monitoring (95950, 95951, 95953 or 95956) is appropriate for certain diagnoses such as seizure disorders, meningococcal encephalitis or unspecified coma. Polysomnography and Sleep Studies: According to our policy, which is based on CMS Policy, providers should not submit two separate claims if they perform a split-night service on a single night.
Observation Services Policy - Facility Observation Services-Frequency of Observation Care: According to our policy, which is based on CMS Policy, in only rare and exceptional cases do outpatient observation services span more than 48 hours. **Observation Services Policy -** Facility Observation Services- Direct Admission without Paid Observation Services: According to CMS policy, direct admission to observation from a physician's office (G0379) requires hospital observation service, per hour (G0378), to be present and in a payable status for the same date of service
Place of Service Policy - Inpatient Only Services (outpatient hospital facility): According to CMS policy, which is also our policy, certain service codes have been identified that may only be performed in an inpatient setting. The reasons for restricting these procedures to the inpatient setting include the invasive nature of the procedure; the need for postoperative care following surgery or the underlying physical condition of the patient requiring surgery. These procedures would not be expected to be reported in on an outpatient hospital facility setting.

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Inpatient-Only Procedures and Non-Inpatient Surgical Services: Additionally, any services billed on the same date as a denied Inpatient Only procedure will be denied unless a non-inpatient surgical service is also billed.
Place of Service Policy - Special Services, Procedures and Reports: According to the AMA CPT Manual, by definition codes 99050 (Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed) and 99051 (Services provided in the office during regularly scheduled evening, weekend or holiday office hours) are for services provided in the office setting. They should not be used in settings other than physician's office.
Radiology Policy - Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope: According to the American College of Emergency Physicians, the American Heart Association and the American College of Cardiology Foundation, computed tomography (CT) of the head or brain, computed tomographic angiography (CTA) of the head, magnetic resonance angiography of the head, or magnetic resonance imaging (MRI) of the brain should not be performed routinely for evaluation of syncope, in the absence of related neurologic signs and symptoms.
Revenue Code Policy - Revenue Code-HCPCS Code Links: According to the Official UB-04 Data Specifications Manual, certain revenue codes require an appropriate HCPCS code to be billed on the same line. The reporting the most specific revenue code for the HCPCS/CPT code reported is considered correct coding and care should be taken to code these services correctly.

Any questions or concerns please Aetna Better Health of Louisiana Provider Relations by calling **1-855-242-0802**, and **selecting option 2** then **option 6**.

Thank you,

Aetna Better Health of Louisiana

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