**Aetna Better Health® of Pennsylvania**
**Aetna Better Health® Kids**
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# CLINICAL PAYMENT, CODING AND POLICY CHANGES

## NEW POLICY UPDATES – EFFECTIVE NOVEMBER 1, 2019:

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.

### Changes below are effective for dates of service beginning November 1, 2019:

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| **EMG/NCV-Limit Units for Diagnosis of Diabetic Polyneuropathy**<br>New policy guidelines for EMG/NCV testing for a diagnosis of diabetic polyneuropathy:<br><br>Needle EMG-Per our policy, which is based on Aetna guidelines, when needle EMG procedures are reported for a diagnosis of diabetic polyneuropathy the number of units should not exceed 3 in any combination.<br><br>Nerve Conduction Studies with F-Wave-Per our policy, which is based on Aetna guidelines, when a nerve conduction with F-wave procedure is reported for a diagnosis of diabetic polyneuropathy the number of units should not exceed 4 per day.<br><br>Sensory Nerve Conduction Studies-Per our policy, which is based on Aetna guidelines, when sensory nerve conduction procedures are reported for a diagnosis of diabetic polyneuropathy the number of combined units should not exceed 4 per day.<br><br>Neuromuscular Junction Testing (Repetitive Stimulation)- Per our policy, which is based on Aetna guidelines, neuromuscular junction testing is considered experimental/investigational for diabetic polyneuropathy. |
| **Scope of Practice Policy – Sleep Studies**<br>Sleep studies should be performed by physician specialty (example-providers certified as a Sleep Disorder specialty) that would indicate special skills and training to perform and interpret the studies. |
| **Video EEG and Observation Care**<br>Per our policy, when a video EEG is reported observation care is considered bundled and therefore not separately reimbursed. |
| **Excision Procedure Billed with Mismatched Diagnosis Code for Size of Lesion**<br>Excision of lesions procedures (CPTs 11400-11471, 11600-11640) all specify size of lesion excised. Upcoding of lesions (determined by a mismatch between the CPT codes for a lesion of a certain size when the diagnosis code indicates the lesion was smaller) is considered incorrect coding. |
| **Medicare Diabetes Prevention Program (MDPP)** |

Per CMS guidelines, The Medicare Diabetes Prevention Program (MDPP) expanded model was created to prevent the onset of type-2 diabetes for Medicare beneficiaries with a pre-diabetes indication.

-Modifier VM (MDPP virtual make-up session) should not be appended to codes that indicate that the service is the first core session and weight loss maintenance sessions require that the weight be measured in-person at the session.

-According to CMS policy, MDPP services, including the maintenance sessions should be performed only once in a patient's lifetime.

**Multiple Procedure Reduction for Diagnostic Ophthalmology Services**

Per CMS policy, Multiple Procedure Reduction for Ophthalmology Services applies when two or more diagnostic services are performed on the same date of service by the same Tax ID and Specialty. The procedure with the highest RVU price for the technical component is reimbursed at 100% and the technical component for all secondary procedures is reduced by 20%.

**Genetic Testing Policy**

New policy guidelines for genetic testing:

Non-Covered Indications for Genetic Testing-MTHFR [5,10-methylenetetrahydrofolate reductase] [EG, hereditary hypercoagulability] gene analysis, common variants [EG, 677T, 1298C-According to the American College of Medical Genetics and Genomics and the American College of Obstetricians and Gynecologists, MTHFR testing (81291) is not recommended as part of an inherited thrombophilia evaluation in patients with or without a history of recurrent pregnancy loss. MTHFR should not be reimbursed when the only diagnosis on the claim is for thrombophilia, thromboembolic disease or recurrent pregnancy loss,

Non-Covered Indications for Genetic Testing-Oncology DX Breast Cancer Assay-Per our policy, which is based on CMS policy, Oncotype DX ™ breast cancer assay is only covered for patients with estrogen receptor positive status.

Non-Covered Indications for Genetic Testing- Afirma® and ThyroSeq® Testing- According to CMS policy, Afirma® and ThyroSeq® testing for thyroid nodules should not be reported with certain thyroid and parathyroid diagnoses; specifically, malignant thyroid tumors and neoplasm of uncertain behavior of parathyroid glad as the only indications reported for testing.

Tier 1 Molecular Pathology and HCPCS Genetic Analysis/Testing Procedures- - According to CMS policy, there are certain molecular pathology procedures (Tier 1 tests) that are not covered due to the fact they are considered 'screening' (only asymptomatic patients are tested). Example: ·81220-81224: CFTR gene analysis is not a benefit and is a statutorily excluded service.

Non-covered Molecular Diagnostic Services- Genetic Testing for Hypercoagulability / Thrombophilia (Factor V Leiden, Factor II Prothrombin, and MTHFR): According to CMS policy, F2 gene (Prothrombin, coagulation factor II) (81240) and F5 gene (Coagulation factor V) (81241) testing for thrombophilia are considered non-covered services.

Non-covered Molecular Diagnostic Services- Circulating Tumor Cell Marker Assays: According to CMS policy, circulating tumor cell marker assays have insufficient evidence to support reasonable and necessary criteria for reimbursement.

Molecular Pathology Testing for Breast Cancer- Gene Expression Profiling Procedures (Oncotype DX™ (81519); ·Prosigna™ (81520); ·MammaPrint ® (81521):

-According to CMS Policy, oncology (breast), gene expression profiling (81519, 81520, or 81521) must be reported with a diagnosis of breast cancer.

- According to CMS policy, MammaPrint testing (81521) should not be performed more often than twice in a patient's lifetime.

-According to CMS policy, The Prosigna® breast cancer prognostic gene signature assay (81520) is considered only reasonable and necessary for post-menopausal female patients.

-According to CMS policy, the Oncotype DX® breast cancer assay (81519) is only covered for patients with estrogen receptor positive status.

Molecular Pathology Testing for Lynch Syndrome: Lynch Syndrome is an inherited cancer syndrome associated with a genetic predisposition to different cancer types such as colorectal, endometrial, ovarian, stomach, small intestine, hepatobiliary tract, upper urinary tract, brain, or skin.

-According to CMS policy, genetic testing for Lynch Syndrome (81288, 81292-81300, 81317-81319) requires prior screening by immunohistorychemistry (IHC) testing (88341, 88342, or 88344) and/or microsatellite instability (MSI) analysis (81301) within the previous 30 days.

- According to CMS policy, certain personal history diagnoses should not be reported as the primary/first-listed/principal diagnosis. Example ICD10 Z85.00 (Personal history of malignant neoplasm of unspecified digestive organ) should not be the primary/first/principal diagnosis

Molecular Pathology Testing for Ovarian Cancer- According to the Federal Drug Administration (FDA) device guidelines, OVA1™ testing (81503) is limited to patients over 18 years of age.

Molecular Pathology Testing for Mastocytosis- According to CMS policy, mastocytosis KIT gene analysis (81273) is considered medically necessary for patients who have mastocytosis to guide in the therapeutic decision making. Mastocytosis is the only appropriate indication to report with this gene analysis procedure.

BRCA1 and BRCA2 Genetic Testing-

- According to CMS policy, BRCA1 and BRCA2 genetic testing (81162-81167, 81212, 81215-81217) reported for a patient 60 years of age or younger with a diagnosis of breast cancer requires a secondary diagnosis of estrogen receptor status.

- According to CMS policy, BRCA1 and BRCA2 genetic testing (81162-81167, 81212, 81215-81217) is not considered reasonable and necessary for patients less than 18 years of age.

Coronary Artery Disease (CAD) Testing- The Corus® CAD test is a blood test taken to determine if the patient’s symptoms may be due to obstructive coronary artery disease (CAD).

- According to CMS policy when Corus® CAD testing is reported with a diagnosis concerning

possible coronary artery disease, a secondary diagnosis indicating a comorbid condition is also required (example-essential hypertension, metabolic syndrome etc.).

- According to CMS policy, Corus® CAD test (81493) should only be performed once in a patient's lifetime.

Genomic Sequencing Procedures-Chromosomal Microdeletion Analysis-According to the American College of Obstetricians and Gynecologists and Society of Maternal Fetal Medicine guidance,

chromosomal microdeletion analysis has not been clinically validated and is considered as experimental/investigational.

Fetal Aneuploidy Testing-Aneuploidy testing is used to screen for fetal chromosomal abnormalities. Further diagnostic testing will be necessary if the screening indicates a moderate or high risk for genetic problems.

-According to the American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine guidelines, fetal aneuploidy testing should not be performed on women with multiple gestations since the screening depends on maternal blood and will not be able to distinguish between fetuses.

- According to the American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine guidelines, fetal aneuploidy testing should not be performed on a fetus less than ten weeks gestational age since after ten weeks, 10% of the total circulating cell-free DNA in the maternal serum is derived from the placenta and can be used to test for fetal disorders.

**Drug and Biological Policy-National Drug Code (NDC)**

National Drug Codes are 11-digit codes used to uniquely identify drug products in the United States. These codes provide additional information above and beyond the HCPCS and CPT classification systems, which generally only describe the active ingredient and dose. NDCs describe the labeler, product, and packaging. CMS requires NDCs to be billed for Medicaid claims, DME claims, and not otherwise classified drug codes (e.g., J9999). Drug manufacturers require accurate NDC data to provide rebates to payers for drugs billed from outpatient and professional providers.

New policies concerning NDCs below:

Invalid NDC Numbers-According to CMS policy, providers are required to bill valid National Drug Code (NDC).

NDC Crosswalk**-**According to CMS policy, providers are required to bill National Drug Code (NDC) numbers with certain drug codes. The NDC number must match the drug code being billed. Additionally, non-specific HCPCS drug codes are separately handled from the HCPCS codes that have specific or definitive code definitions. The non-specific HCPCS drug codes include codes that have not otherwise specified language (ex. J8999), unclassified language (ex. J3490), or miscellaneous/general use language (ex. A4211) in the code description.