Aetna Better Health® of Pennsylvania
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NEW POLICY UPDATES – AUGUST 1, 2019: 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 August 1, 2019:

Inpatient Claim Data Validation-According to our policy, which is based on CMS, the discharge status may be necessary for appropriate Diagnosis Related Group (DRG) determination and must be submitted as a valid code. Therefore, when the discharge status code is not valid for the date of service submitted, the claim will be denied.
Diagnosis Code Guideline Policy-ICD-10-CM Sequela (7th character "S") Codes-The ICD10 manual defines sequela as "the residual effect (condition produced) after the acute phase of an illness or injury has terminated". Coding of sequela requires 2 codes-coding/reporting of the condition or nature of the sequela and the sequela (7th character "S") code. Sequela diagnosis codes should not be the only diagnosis reported on a claim.
Duplicate Services Policy-Duplicate Claim Logic for Inpatient Claims-A duplicate claim as a claim or claim line that has been previously processed for payment claims deemed to be a duplicate will be denied. This concept applies to inpatient facility claims based on matching criteria which includes (but is not limited to) date of service, member ID, DRG, etc. This correct coding concept applies to inpatient facility claims.
Diagnosis-Age Policy- Diagnosis-Age Consistency- Certain diagnosis codes have been identified as being specific to certain age groups. The patient's age and diagnosis code age should match. This correct coding concept applies to inpatient facility claims.
No Pay Billing-According to our policy, which is based on the National Uniform Billing Committee, certain bill types are not payable based on definition. No-pay bill types can be identified by the presence of a "0" as the final digit of the bill type. These bill types are used when a provider does not anticipate payment for the bill but is informing the payer about a period of non-payable confinement or termination of care.