Aetna Better Health® of Pennsylvania
2000 Market Street Ste. 850
Philadelphia, PA 19103

NEW POLICY UPDATES – JULY 31, 2018:
CLINICAL PAYMENT, CODING AND POLICY CHANGES

Effective for dates of service beginning July 31, 2018:

Bundled Facility Payment Policy-Ambulance Services Bundled to the Facility Admission -#1

According to CMS policy, once a member is admitted to an Inpatient Hospital or Critical Access Hospital (CAH), it may be necessary to transport the member to another hospital or other site temporarily for specialized care while the member maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service. Transportation services are not separately payable from the payment to the inpatient institution. This policy is applicable to professional claims only and does not reference other claim types.

Bundled Facility Payment Policy- Ambulance Services Bundled to the Facility Admission -#2

According to CMS policy, once a member is admitted to an Inpatient Hospital or Critical Access Hospital (CAH), it may be necessary to transport the member to another hospital or other site temporarily for specialized care while the member maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service. Transportation services are not separately payable from the payment to the inpatient institution. This policy uses all claims billed in a patient's history (Professional, Outpatient facility and inpatient facility) to determine if a qualifying inpatient hospital has been reported.

Dermatology Policy-Laser Treatment of Psoriasis

According to the AMA CPT Manual and CMS policy, laser treatment of psoriasis should only be reported with a diagnosis of psoriasis or parapsoriasis.

Duplicate Services Policy-Duplicate Claims From a Non-Physician Practitioner (NPP) Under Same Tax ID

According to our policy, when the same codes are billed for the same date of service by a non-physician practitioner (NPP) with the same Tax ID and the primary diagnosis matches any diagnosis on the previous claim reported by another physician/midlevel provider in the same group (same Tax ID), this scenario is considered a duplicate service.

Gastroenterology Policy-Colonoscopy

According to the American College of Physicians, United States Preventive Service Task Force, and American Gastroenterological Association Policy, colorectal cancer screening is covered routinely only for patients 50 years of age and older. Patients under 50 should only require a screening colonoscopy if the patient is high risk.

Laboratory-Pathology Policy-Vitamin D Testing

According to the Endocrine Society and the American Association for Clinical Chemistry, measurement of serum Vitamin D; 1, 25 dihydroxy is not recommended as a screening study.

Neurology Policy-Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy

According to the American Association of Neuromuscular & Electrodiagnostic Medicine and CMS Policy, nerve conduction studies [NCS] and a needle electromyography [EMG] must both be performed in order to diagnose radiculopathy (pinched nerve in back or neck). When the NCS or the needle EMG is used on its own, the results can be misleading and important diagnoses may be missed.

Obstetrics and Gynecology Policy

Cervical Cancer Screening- According to the American College of Obstetricians and Gynecologists (ACOG) and the U.S. Preventive Services Task Force (USPSTF), cervical or vaginal screening is not recommended to be performed annually for women age 21 years of age or older as there is no advantage over performing screening at 3-year intervals for average risk women.

Cervical Cancer Screening- According to the American College of Obstetricians and Gynecologists (ACOG) and the U.S. Preventive Services Task Force (USPSTF), cervical or vaginal screening is not recommended for female patients less than 21 years of age (regardless of sexual history), as cervical cancer is rare in young women and screening leads to unnecessary treatment which increases the risk of reproductive problems.

Once Per Lifetime Services Policy- Services Following a Medical Event-Hysterectomy

There are certain medical events that occur to a patient that affect the services that can subsequently be billed for the patient. Services that would be performed on or for anatomic structures that are no longer present cannot physically or technically be carried out. According to CMS Policy, services, such as these, which are not reasonable and necessary for the diagnosis or treatment of an illness or injury are not covered.

Uterine Services-A uterine service medical event would be the removal of the entire uterus including the cervix. If a patient has undergone a total hysterectomy, certain uterine surgical and diagnostic services cannot be performed since the required anatomical structures for the procedure or service are no longer present.

Ophthalmology Policy- Scanning Computerized Ophthalmic Diagnostic Imaging [SCODI]

According to CMS policy, it would rarely be necessary to perform scanning computerized ophthalmic diagnostic imaging (SCODI) of the optic nerve more than once per year for patients whose primary ophthalmological condition is not related to glaucoma.

Physical Medicine Policy

Therapeutic Services-Canalith Repositioning- According to CMS policy, canalith repositioning procedure is indicated for benign paroxysmal positional vertigo (BPPV) and should be reported with a diagnosis that reflects BPPV.
Physical Medicine Policy-Iontopheresis-According to CMS policy, iontophoresis (introduction into the tissues, by means of an electric current, of the ions of a chosen medication) is only indicated for primary focal hyperhidrosis and should be reported with that diagnosis.

Anesthesia Policy-Anesthesia Crosswalk

When surgical procedure codes are billed by anesthesiologists or CRNAs, Cotiviti will crosswalk these procedure codes to the anesthesia service code with the lowest base unit value when there is an option. This crosswalk allows for edits, such as the National Correct Coding Initiative, to be applied appropriately and also prevents other policies from inappropriately being applied.

On 1450s for Professional Rev Codes-Modifiers-If a surgical code is billed on a CMS-1450 with Professional Revenue Codes Revenue Codes 0960-0989 (Professional fees) and any anesthesia modifiers is appended, that surgical code will be cross walked to the appropriate anesthesia CPT code.

Anesthesia for Gastrointestinal Endoscopic Procedures- According to the American Society of Gastrointestinal Endoscopy, routine gastrointestinal endoscopy procedures usually do not require general or monitored anesthesia in average risk patients. Anesthesia for upper (00731) or lower (00811, 00812) gastrointestinal endoscopy procedures for a patient older than 18 years of age and less than 70 years of age will be denied without a diagnosis that indicates medical necessity or a physical status modifier P3, P4, P5, P6 or MAC modifier G9. Examples of high risk would be ischemic heart disease; dementia; gastric ulcer with hemorrhage.

Anesthesia for Pain Management Injections- According to the American Society of Anesthesiologists and the International Spine Intervention Society, minor pain management procedures such as epidural steroid injections, epidural blood patch, trigger point injections, sacroiliac joint injection, bursal injections, occipital nerve block and facet injections under most routine circumstances, require only local anesthesia. Anesthesia and moderate sedation services billed with pain management services) for a patient 18 years of age or older will be denied unless a surgical procedure (other than a pain management procedure) is also present. An exception will apply for anesthesia services billed with modifiers indicating severe systemic disease (physical status modifiers P3, or P4, or monitored anesthesia care modifier G9).

Anesthesia Modifiers for Anesthesia Services- According to CMS policy, physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, medically supervised, or represented monitored anesthesia care. Similarly, CRNA's must report the appropriate anesthesia modifier to indicate whether the service was performed with or without supervision by a physician. Additionally, it is not appropriate to bill multiple anesthesia modifiers AA, AD, QK, QX, QY and QZ on the same claim line as they are considered mutually exclusive.

Certified Registered Nurse Anesthetist (CRNA) Services- According to CMS policy, anesthesia services (00100-01999) billed by a CRNA (Certified Registered Nurse Anesthetist) require the appropriate modifier to designate whether the service was performed with or without medical direction by a physician. (CRNA modifiers are QX (Qualified non-physician anesthetist with medical direction by a physician) and QZ (CRNA without medical direction by a physician)).

Daily Management of Epidurals with Qualifying Circumstance Codes and Physical Status Modifiers- According to the American Society of Anesthesiologists Relative Value Guide, daily hospital management of epidural or subarachnoid continuous drug administration should not be reported with anesthesia qualifying circumstance codes. Qualifying circumstance codes are used to indicate that anesthesia services are provided under difficult circumstances which may present unusual operative conditions and or risk factors for the patient. They should be reported in addition to the primary anesthesia procedure codes; therefore, the daily hospital management of epidural or subarachnoid continuous drug administrations will be denied if reported with 99100-99140 and an anesthesia procedure code is not also present.

Additionally, physical status modifiers P1-P6 should not be reported with daily hospital management of epidural or subarachnoid continuous drug administration (01996) as they distinguish various levels of complexity of anesthesia provided to the patient.

Anesthesia Policy-Anesthesia Crosswalk (cont.)

Duplicate Anesthesia Services on the Same Day- If an anesthesiologist personally administers anesthesia (Modifier AA), additional payments to a Certified Registered Nurse Anesthetist (CRNA) identified by modifiers QX or QZ will be denied. Similarly, if a CRNA has been paid for the procedure (Modifiers QX or QZ), the anesthesiologist service will be denied (Modifier AA).

Frequency of Epidural and Facet Injections**-:**

- According to CMS policy, diagnostic and therapeutic epidural or subarachnoid injections are limited to eight times per region in a year.
- According to CMS policy, diagnostic and therapeutic paravertebral facet joint injections are limited to eight times per region in a year.
- According to CMS policy, up to eight transforaminal epidural injection sessions per region may be performed in a year: up to two diagnostic and up to six therapeutic.

Medical Supervision and Medical Direction of Anesthesia Services- Per the HCPCS Manual, there are certain modifiers that indicate the number of qualified individuals for which an anesthesiologist is providing medical direction. When a claim is submitted by a CRNA or other qualified individual rendering anesthesia services under medical direction, then the anesthesiologist is required to utilize one of the below modifiers indicating that medical direction or medical supervision was provided.

Medical direction and medical supervision modifiers:

- QY (Medical direction of one qualified non-physician anesthetist by an anesthesiologist)
- QK (Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals)
- AD (Medical supervision by a physician: more than 4 concurrent anesthesia procedures)

Similarly, a CRNA should report the appropriate modifier when medical direction is provided by an anesthesiologist. When a claim is submitted by an anesthesiologist indicating that medical supervision or medical direction was provided, then a CRNA claim submitted with modifier QZ (CRNA service without medical direction by a physician) is incorrect will be denied.

Multiple General Anesthesia Services on Same Day (Both Professional (1500) And Outpatient Facility-(1450)- When multiple anesthesia services are billed for the same day, the anesthesia provider should bill only the general anesthesia service for the procedure with the highest base value, plus the time for all anesthesia services combined. When a claim is received that contains multiple general anesthesia service codes (00100-01999), the highest submitted charge amount will be paid and the secondary anesthesia services will be denied.