Aetna Better Health® of New Jersey

3 Independence Way, Suite 104
Princeton, NJ 08540

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. To keep our providers informed, please see the below chart of upcoming new policies.

Effective for dates of service beginning **January 1, 2024**:

CMS Coverage Policies- Unauthorized COVID-19 Monoclonal Antibodies, Vaccines, and Related Administration- According to our policy, which is based on CMS Policy and the Food and Drug Administration (FDA), certain monoclonal antibodies used to treat COVID-19 are not authorized in the United States for the reported date of service.
Device and Supply Policy – Pass-Through and Non-Pass-Through Drugs and Biologicals Require an OPPS-Payable Procedure – According to our policy, which is 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 – According to our policy, which is 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 - According to our policy, which is 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 - According to our policy, which is 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 – According to our policy, which is 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 – According to our policy, which is 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.
Modifier Policy-Modifier CS- Effective DOS 5/12/2023, CMS (COST SHARE COVID-19) considers the CS modifier to be an invalid modifier now that the Public Health Emergency. Modifier CS should not be appended to any services after the PHE has ended.