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NETWORK NOTICE

Date: April 16, 2020
To: Network Providers
From: Provider Experience
RE: **AEFX00086: 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 May 16, 2020:

Polysomnography/Sleep Studies-Per our policy, which is based on CMS Local Coverage Determination policy, polysomnography (CPT codes 95782, 95783, 95808, 95810 or 95811) is defined as "a sleep test involving the continuous, simultaneous, recording of physiological parameters for a period of at least 6 hours that is performed in a sleep laboratory and attended by a technologist or qualified health care professional." This test should only be performed if medically necessary, for example narcolepsy or hypersomnia.

Polysomnography-Daily Limits-Per our policy, which is based in CMS Policy (Office of Inspector General reporting), only one unit of polysomnography (CPT codes 95782, 95783, 95808, 95810 or 95811) should be reported per date of serve regardless of combination of different services reported.

Polysomnography-Home Sleep Studies-Per our policy, which is based on CMS Local Coverage Determination policy, home sleep study testing (CPTs G0398, G0399, G0400) must be performed in conjunction with a comprehensive sleep evaluation. There should be an evaluation and management service in the 6 months prior to a home sleep study.

Polysomnography/Sleep Studies-Limits-Number Allowed in a 3-year period-Per our policy, which is based on CMS guidelines (Office of Inspector General reporting), it is rarely medically necessary for beneficiaries to receive multiple polysomnography services (CPT codes 95782, 95808 or 95810) in consecutive years. No more than 2 studies in a 3-year period would be medically necessary to manage a patient's sleep issues.

Polysomnography/Sleep Studies-Repeated Titrations-Per our policy, which is based on CMS guidelines (Office of Inspector General reporting), it is rarely medically necessary for a beneficiary to undergo more than two titration services (CPT codes 95783 or 95811) in such a short time. No more than 3 titration studies in a 90-day period would be medically necessary to manage a patient's sleep issues.

Polysomnography/Sleep Studies- Unbundling a split-night service-Per our policy, which is based on both CMS Local Coverage Determination guidelines and Offices of Inspector General reporting, it is unusual for a provider to perform two diagnostic and titration services on consecutive nights (CPT codes 95782, 95783,

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95808, 95810 or 95811). Because a split-night service involves only one overnight stay, submitting two polysomnography claims for a split-night service constitutes inappropriate unbundling.

Polysomnography/Sleep Studies- Unattended Sleep Studies-Per our policy which is based on CMS Local Coverage Determination guidelines, unattended sleep studies (CPT codes 95800, 95801, 95806, G0398, G0399, or G0400) are covered only for the diagnosis of obstructive sleep apnea

Polysomnography/Sleep Studies- Unattended Sleep Studies-Limitations-Per our policy, which is based on CMS Local Coverage Determination guidelines, home sleep studies (CPT codes G0398, G0399 or G0400) should be reported only once per year. More than one Home Sleep Study per year interval would not be expected.

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

Ophthalmology Services-Per our policy, which is based in CMS IOM Publication 100-02 (Medicare Benefit Policy) guidelines, an ophthalmology service medical event would be the removal of an eye or its contents. If a patient has undergone evisceration, enucleation or exenteration of an eye, then certain ophthalmology services, such as a diagnostic eye examination, cannot be billed for the eye structures that were removed.

Upper Limb Services-Per our policy, which is based on CMS IOM Publication 100-02 (Medicare Benefit Policy) guidelines, an upper limb service medical event would be amputation of the shoulder, arm, forearm, wrist or hand. Once a patient has had an upper extremity amputation, certain upper limb services cannot be performed on the same arm since the required anatomical structures for the procedure or service are no longer present.

Lower Limb Services-Per our policy, which is based on CMS IOM Publication 100-02 (Medicare Benefit Policy) guidelines, a lower limb service medical event would be amputation of the leg (at the hip joint, below the knee or above the knee), or foot (including ankle or ankle disarticulation). Once a patient has had a lower extremity amputation, certain lower limb services cannot be performed on the same leg since the required anatomical structures for the procedure or service are no longer present.

Thoracic and Abdominal Region Services-Per our policy which is based on CMS IOM Publication 100-02 (Medicare Benefit Policy) guidelines, a thoracic region medical event would be the removal of an entire lung. If a patient has undergone a total pneumonectomy, then certain services related to the lung cannot be performed on the same side since the required anatomical structure for the services is no longer present., Additionally, an abdominal region medical event would be the removal of the entire stomach. If a patient has undergone a total gastrectomy, then certain gastric services, such as biopsy of the stomach, cannot be performed since the required anatomical structure for the procedure has been removed.

Renal Services-If a patient has had a total nephrectomy (kidney removal) certain renal services cannot be performed since the required anatomical structure has been removed.

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Ophthalmology Policies

Special Ophthalmological Services-Per our policy, which is based on AMA CPT Manual and the American Academy of Ophthalmology guidelines defines special ophthalmologic procedures (CPT codes 92020-92287, 76510-76514, 76516, 76519, 0506T, 0507T) as not routinely part of a comprehensive medical eye evaluation; rather, these procedures should be performed for a specific finding encountered during a history and physical examination.

Ophthalmoscopy-Diagnosis Requirement for Extended Ophthalmoscopy-Per our policy, which is based on the American Academy of Ophthalmology and CMS Local Coverage Determinations Policy guidelines, extended ophthalmoscopy (CPTs 92225-92226) is a detailed exam of the fundus (posterior part of the interior of the eye including the vitreous humor, the retina, the macula, the optic nerve and retinal veins and arteries) and is not performed routinely as part of a comprehensive medical eye evaluation, but is appropriate if evidence of fundal disease is found during routine ophthalmoscopy.

Ophthalmoscopy-with Fundus Photography-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, ophthalmoscopy with a retinal drawing (CPT codes 92225-92226) is considered redundant when performed with fundus photography (CPT codes 92250) as a drawing is not needed when photographic documentation of the area is performed.

Ophthalmoscopy-with Fluorescein Angiography-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, extended ophthalmoscopy with retinal drawings (CPT codes 92225-92226) should not be billed on the same day as fluorescein angiography (CPT code 92235).

Ophthalmoscopy-Place of Service-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, an extended ophthalmoscopy (CPT codes 92225-92226) must be performed in an appropriate setting which includes (but not limited to) physician's office, outpatient hospital-off campus, urgent care facility, inpatient hospital etc.

Ophthalmoscopy-Frequency-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, the frequency of ophthalmoscopy (CPT codes 92225-92226) should be determined by the condition being monitored. In the absence of an indication requiring more frequent screening (i.e., neoplasms of the eye, glaucoma to name only two), ophthalmoscopy should be limited to two units per eye per year; 4 units per year for a diagnosis of neoplasms; 6 units per year for diagnoses indicating disorders of the globe, choroid, retina, iris and ciliary body or glaucoma; and 12 units per eye per year when the diagnosis is exudative senile macular degeneration.

Visual Field Examination-Per our policy, which is based on the American Academy of Ophthalmology and CMS Local Coverage Determinations Policy guidelines, visual field examinations (CPT codes 92081-92083) should not be performed routinely on patients without signs of visual field defects on gross examination by direct confrontation, or without a disease or risk factor affecting the field of vision.

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Fundus Photography-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, the recommended frequency for fundus photography (CPT code 92250) is no more than two times per 12 months except when a diagnosis requiring additional units is reported.

Ophthalmic Angiography (Fluorescein and Indocyanine-Green)-Per our policy, based on CMS Local Coverage Determinations Policy guidelines, fluorescein angiography (CPT code 92235) is considered medically necessary no more than nine times per year, per eye. Additionally, per CMS, indocyanine-green angiography (CPT code 92240) is considered medically necessary no more than nine times per year, per eye.

Scanning Computerized Ophthalmic Diagnostic Imaging [SCODI]-Anterior/Posterior Segment-Indications- Per our policy, based on the American Academy of Ophthalmology and CMS Local Coverage Determinations Policy guidelines, scanning computerized ophthalmic diagnostic imaging (SCODI) of the anterior segment (CPT code 92132) is indicated only for evaluation of certain conditions, such as specified forms of glaucoma, or disorders of the cornea, iris or ciliary body.

Additionally, per American Academy of Ophthalmology and CMS Local Coverage Determinations Policy guidelines, scanning computerized ophthalmic diagnostic imaging (SCODI) of the posterior segment (CPT codes 92133 or 92134) is indicated only for conditions describing damage to the optic nerve or retina.

Scanning Computerized Ophthalmic Diagnostic Imaging [SCODI]-Frequency- Per our policy, based on CMS Local Coverage Determinations Policy guidelines, it would rarely be necessary to perform scanning computerized ophthalmic diagnostic imaging SCODI of the retina (CPT code 92134) more than once per month for patients whose primary ophthalmological condition is related to retina disease; SCODI of the optic nerve or retina more (CPT codes 92133 and 92134) than two units per year for patients with damage related to glaucoma; SCODI of the optic nerve (CPT 92133) more than once per year for patients whose primary ophthalmological condition is not related to glaucoma; and SCODI of the retina (CPT code 92134) more than once per year for patients whose primary ophthalmological condition is not related to glaucoma or retina disease.

Ophthalmic Ultrasound- Per our policy, which is based the American Academy of Ophthalmology, ultrasound biomicroscopy (UBM) (CPT code 76513) is not an appropriate procedure for imaging the anterior chamber for glaucoma, except when a rarer glaucoma type is present such as anatomical narrow angle glaucoma.

Corneal Pachymetry-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, corneal pachymetry CPT code 76154) performed for diagnosis glaucoma or ocular hypertension (OHT) (ICD-10 codes H40-H42, Q15.0) or glaucomatous optic atrophy (ICD-10 codes H47.23-H47.239) should only be billed once in a patient's lifetime.

Glaucoma Screening- Per our policy, based on CMS Local Coverage Determinations Policy guidelines, glaucoma screening procedures (CPT codes G0117 or G0118) are limited to one visit within a 335-day period and should be reported as a screening test only.

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Cataract Surgery- Discussion of Secondary Membranous Cataract Following Cataract Surgery-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, posterior capsular opacification rarely occurs within 3 months of cataract surgery (CPT code examples- 66830-66940). Laser surgery (CPT codes 66821) in the global surgical period of another cataract surgery will only be reimbursed when documentation justifies the need for the procedure.

Cataract Surgery- iStent and CyPass with Cataract Surgery-Per our policy, which is based on CMS guidelines, certain anterior segment aqueous drainage devices are only appropriate when used in combination with cataract surgery. The iStent® device (CPT codes 0191T) was created as a micro-invasive glaucoma surgery device. The Cypass® device (CPT code 0474T) is a micro-stent system created for the same purpose. These devices should be reported on the same day as cataract surgery (CPT code examples- 66830-66940).

Implantable Miniature Telescope (IMT)-Per our policy, which is based on CMS Local Coverage Determinations Policy guidelines, insertion of an ocular telescope prosthesis including removal of the crystalline lens (0308T or C1840) is only covered for a diagnosis of nonexudative senile macular degeneration of the retina (ICD-10 codes H35.31-H35.3194). Additionally, CMS Regional Local Coverage Determinations Policy guidelines, insertion of an ocular telescope prosthesis is covered only for patients 65 years of age or older.

Questions? Simply contact your Network Relations Manager at: **www.aetnabetterhealth.com/kentucky.**

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