Aetna Better Health® of Michigan

28588 Northwestern Hwy, Suite 380B
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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 March 1, 2023:

Claims Processing Parameters Policy- Timely Filing Limits for Medicare Fee For Service Claims- According to CMS policy, Medicare fee for service claims must be filed to the appropriate Medicare claims processing contractor no later than 12 months, or one calendar year (366 days), after the date the services were furnished.
CMS National Coverage Determinations (NCD) Policy- Implantable Cardiac Defibrillators (ICDs)- An Implantable Cardiac Defibrillator (ICD) is an electronic device for sensing and defibrillating that helps in diagnoses and treatment of life-threatening Ventricular Tachyarrhythmias (VTs). Diagnosis Requirement- According to CMS policy, implantable cardiac defibrillators must be reported with an appropriate diagnosis. Example: Old myocardial infarction; Ventricular tachycardia. Additionally, according to CMS policy, dual device defibrillator/ pacemaker procedures must also be reported with an appropriate diagnosis. Example: Carotid sinus syncope; Congenital heart block. Finally, according to our policy, which is based on CMS Policy, ICD (Implantable Cardiac Defibrillator) services for a diagnosis of post myocardial infarction or cardiomyopathy is not covered unless an appropriate heart failure diagnosis is also reported.
Evaluation and Management Services Policy- Care Management Services- Chronic and Complex Care Management Services- - According to our policy, which is based on the AMA CPT Manual, patients who receive chronic care management services or complex chronic care management services must have multiple (two or more) chronic continuous or episodic health conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. - According to our policy, which is based on the AMA CPT Manual, care management services should only be reported once per calendar month and may only be reported by the single provider who assumes the care management role with a particular patient for the calendar month. - According to the AMA CPT Manual, end-stage renal disease (ESRD) services, telephone assessment and management services, domiciliary/rest home care supervision and medical team conference services should not be separately reported by the same provider that reported care management services during the same calendar month (31 days). - According to AMA CPT Manual, chronic and/or principal care management services should not be reported more than twice in the same calendar month. Frequency Limitation- Behavioral Care Management Services- According to the AMA CPT Manual, behavioral health integration care management service should not be reported more than once in the same calendar month.

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Behavioral and Psychiatric Care Management Services- According to our policy, which is based on the AMA CPT Manual, behavioral health integration care management and psychiatric collaborative care management may not be reported by the same professional provider in the same month.

Multiple Psychiatric Care Management Services-According to our policy, which is based on the AMA CPT Manual, behavioral health integration care management and psychiatric collaborative care management may not be reported by the same professional provider in the same month. According to the AMA CPT Manual, the initial psychiatric collaborative care management service should only be reported for the first calendar month. Services on subsequent days should be reported with the subsequent psychiatric collaborative care management visit code.