Aetna Better Health® of Virginia
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AETNA BETTER HEALTH® OF VIRGINIA

New Policy Updates – Clinical Payment, Coding and Policy Changes

Dear Provider:

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 **September 27, 2022**:

Professional, Technical, and Global Services Policy Professional Component Billed in the Office Setting: According to our policy, which is based on the AMA Principles of CPT Coding, the review or reread of radiology procedures is considered part of the Evaluation and Management (E/M) service when reviewed in a physician's office. Professional Component of Radiology Services in Facility Places of Service: According to our policy, reporting of an x-ray procedure requires permanently recorded images. In addition, the professional component (interpretation) of radiological procedures should only be reported by the provider who provided the formal written interpretation and report.
Procedure Code Definition Policy Per our policy, which is based on the AMA/CPT and HCPCS manuals, correct coding will be enforced based on procedure code definition instruction. For example, if the procedure code for an osteoplasty, radius OR ulna; shortening is billed with the procedure code for an osteoplasty, radius AND ulna; shortening for the same side of the body, then only the code for the osteoplasty radius AND ulna; shortening will be allowed as this procedure includes osteoplasty radius OR ulna.
Place of Service Policy: Physician Fee Schedule Non-Facility NA Indicator According to our policy, which is based on CMS policy, some procedures or services are not appropriate in an office setting. Procedures that are more extensive or require anesthesia should be performed in a setting where the procedure can be performed safely.
Cardiology Policy-Frequency of Echocardiographies According to our policy, when an initial, complete study is performed, and another study is performed within six months for the same diagnosis, this latter study should represent a follow-up study given the fact that the complete study has already been done recently for the same condition.
Scope of Specialties Billing Certain Services Laboratory/Pathology: According to our policy, which is based on the CMS policy, laboratory and pathology procedures require the skill and training of a provider who specializes in laboratory/pathology in order to provide the official interpretation and report for the study. Anesthesia: According to our policy, which is based on the CMS policy, anesthesia services require the skill and training of a provider who specializes in anesthesia.
Evaluation and Management Services Policy Multiple Evaluation and Management Services on the Same Day: According to the AMA CPT Manual, a provider should only bill a new patient or an initial care visit for one date of service. Subsequent visits should be submitted using the appropriate established patient or facility follow-up codes.