Aetna Better Health® of Michigan
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Provider Bulletin No 207

AETNA BETTER HEALTH® OF MICHIGAN

TO: Providers
FROM: Provider Experience Team
DATE: June 8, 2022
SUBJECT: New Policy Updates – Clinical Payment, Coding and Policy Changes

Dear Provider,

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 **AUGUST 1, 2022**:

Evaluation and Management Services Policy-Interprofessional Telephone/Internet Consultations-According to the AMA CPT Manual and HCPCS Level II Manual, telephone evaluation and management service (E/M) services, remote evaluation of recorded video and/or image, or brief check in by MD/Qualified Healthcare Provider 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.
Drug and Biological Policy Processing and Policy Guidelines-National Drug Code (NDC)- According to our policy, which is based on CMS Policy, providers are required to report specific drug HCPCS codes with the certain National Drug Codes (NDC). The NDC must match the specific drug HCPCS code being reported. It is not appropriate to report a drug with a specified HCPCS code with a miscellaneous drug HCPCS code and the NDC should match the specified drug HCPCS code.
Diagnosis Procedure Policy-Procedures That Do Not Remedy a Health State-According to our policy, which is based on CMS Policy, services which are elective in nature and do not remedy a health state are considered noncovered.

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Orthopedic Policy-Injections involving tendons, ligaments and ganglion cysts-Injections into tendon sheaths, ligaments, tendon origins or insertions, or ganglion cysts may be indicated to relieve pain or dysfunction resulting from inflammation or other pathological changes. These injections require that an appropriate diagnosis is reported (e.g., bursitis, carpal tunnel syndrome).
Orthopedic Policy-Percutaneous Fusion of the Sacroiliac Joint-According to CMS policy, percutaneous fusion of the sacroiliac (SI) joint is considered appropriate when at least one therapeutic intra-articular SI joint injection and when x-rays of the pelvis, x-ray of SI joint and CT scans have been performed in the past year.
Gastroenterology Policy-Gastrointestinal Capsule Imaging-According to CMS Policy, when capsule endoscopy is reported, an upper endoscopy and colonoscopy related to the current episode of care, should be performed prior to the capsule endoscopy.
Podiatry Policy-Routine Foot Care-According to CMS policy, routine foot care must be reported with an appropriate modifier indicating certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement when billed with a qualifying diagnosis.

If you have additional question, please contact CICR at:

1-866-316-3784 Monday to Friday 7:00 AM to 4:00 PM

Or your Provider Service Representative directly at:

1-866-316-3784 Monday to Friday 8:00 AM to 5:00 PM