PROVIDER BULLETIN

AETNA BETTER HEALTH® OF FLORIDA 261 N. University Drive Plantation, FL 33324 www.AetnaBetterHealth.com/Florida	**Date:**	**August 14th, 2020**
	Purpose:	**Provider Bulletin: Educate provides on new clinical payment, coding, and policy updates**
	Subject:	**NEW Policies effective date of service 07.28.2020**
	Products:	**All Lines of Business - MMA, LTC, FHK**
	From:	**Provider Relations**

Dear Provider,

This notice is to advise you that Aetna Better Health of Florida regularly augment clinical, payment and coding policy positions as part of our ongoing policy review processes.

In an effort to keep you informed, please review the attached document for the new policies that will affect MMA and FHK line of business for date of service 07.28.2020.

We appreciate the excellent care you provide to our members. If you have any questions please feel free to contact us via e-mail: FLMedicaidProviderRelations@Aetna.com. You can also fax us at 1-844-235-1340 or call us through our Provider Relations telephone line: 1-844-528-5815.

Thank you

Provider Relations Department
Aetna Better Health of Florida

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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 that will affect MMA and FHK line of business.

Policies are effective based on date of service beginning July 28, 2020:

Revenue Code Policy-Revenue Code-HCPCS Code Links

Per our policy, which is based on the Official UB-04 Data Specifications Manual and the Uniform Billing Editor (UBE), revenue code 0636 (drug requiring detailed coding) should be reported with an appropriate HCPCS code.

Claim line is subject of denial when the revenue code is 0636 (Drugs requiring detailed coding) and the HCPCS code does not match.

Hydration Therapy

Hydration is defined as the replacement of necessary fluids by IV infusion which consists of pre-packaged fluid and electrolytes. Per our policy, which is based on CMS Coverage guidelines, the following criteria must be met for hydration infusion to be considered appropriate:

- Diagnosis Requirement-Hydration therapy for adults should be provided for an appropriate diagnosis, e.g. patients being treated for nausea and vomiting or syncope/collapse.
- IV Fluids-per CMS policy and AMA/CPT certain IV fluids (Example-J7030-Normal saline; 1000cc) should not be separately reported with hydration infusion; basic IV fluids are included in hydration infusion.
- Minimum IV Fluid Units-Per our policy, based on CMS policy and the National Institute for Health and Care Excellence, hydration is allowed when provided in volume greater than 501 ML. Anything less than that is considered not reasonable and necessary.

Hydration Therapy claims will be denied based on the following rules:

1. Deny CPT Codes: 96360, J7030, J7040, J7042, J7050, J7060, J7070, J7120 or J7121 (Intravenous fluids) when billed without a requisite diagnosis on the claim and the patient is older than 18 years of age.
2. Deny CPT Codes: J7030, J7040, J7042, J7050, J7060, J7070, J7120 or J7121 (Intravenous fluids) when billed with intravenous infusion hydration (96360) by any provider.
3. Deny CPT Code J7050 (Infusion, normal saline solution, 250 CC) when billed with less than three units and billed without other hydration solutions (J7030,

J7040, J7042, J7060, J7120, J7121) by any provider and the patient is older than 18 years of age.

4. Deny J7040 (Infusion, normal saline solution, sterile [500 ML = 1 unit]) when billed with less than two units and billed without other hydration solutions (J7030, J7042, J7050, J7060, J7070, J7020, J7021) by any provider and the patient is older than 18 years of age.
5. Deny J7042 (5% Dextrose/normal saline [500 ML = 1 unit]) when billed with less than two units and billed without other hydration solutions (J7030, J7040, J7050, J7060, J7070, J7120, J7121) and the patient is older than 18 years of age.
6. Deny J7060 (5% Dextrose/water [500 ML = 1 unit]) when billed with less than two units and billed without other hydration solutions (J7030, J7040, J7042, J7050, J7120, J7121) by any provider and the patient is older than 18 years of age.

Services Rendered to Incarcerated Members

Per our policy, which is based on CMS Coverage guidelines, services rendered to incarcerated members are not payable since the state/local government have the financial obligation to pay the cost of healthcare. This applicable to outpatient hospital facility charges.

Aetna Better Health of Florida will:

1. Deny all services billed on a CMS-1500 form when there exists a facility claim for the same date of service with a discharge status of 21 or 87 unless billed in an inpatient setting. (CMS-1500).
2. Deny all services billed on a CMS-1500 form when there exists a claim on a CMS-1450 form for the same date of service with a discharge status of 21 or 87 unless modifier QJ is appended to any service on either claim line.

Cytogenetic Studies

Per our policy, which is based on CMS policy, cytogenetic studies are allowed only for specific clinical conditions such as genetic disorders of fetus or myelodysplasia. An approved supporting indication is required.

When billing CPT Codes 88230-88291 (Cytogenetic studies) without an approved diagnosis claim will be denied.

Diagnosis-Procedure Policy-Varicose Veins of Lower Extremity

Per our policy, which is based on CMS policy, vascular embolization or occlusion requires that an appropriate diagnosis be reported to support the procedure. Indications such as localized edema or venous insufficiency are not considered appropriate.

Aetna Better Health of Florida will deny 37241 (Vascular embolization or occlusion) when billed and a non-covered diagnosis is the only diagnosis associated to the line.
Evaluation and Management Services Policy-New Patient Visits Per our policy, which is based the AMA/CPT manual and CMS policy, a new patient is one who has not received any professional services from the physician or another physician of the same specialty and subspecialty who belongs to the same group practice, within the past three years. Given this definition, if a physician bills a new patient visit and any face-to-face service has been billed by the same provider ID in the previous three years, the new patient visit will be denied. When any face-to-face service has previously been billed by the same provider ID, regardless of Tax ID or specialty in the last three years, a new patient visit will be denied.
Place of Service Policy-Home Health/Home Infusion Per our policy, which is based on CMS policy, separate payment for home infusion/home therapy services is not made when that member is in an inpatient status. Aetna Better Health of Florida will deny home infusion or home therapy services billed on the same date of service as subsequent inpatient hospital or skilled nursing facility care, When initial inpatient hospital or skilled nursing care is present the day prior and there is not a facility discharge service on the same day by any tax ID, provider ID, or specialty.
Neurology Policy-Polysomnography and Sleep Studies Per our policy, which is based on CMS policy, a comprehensive sleep evaluation should be performed prior to performing the polysomnography to determine if the polysomnography services are warranted. Aetna Better Health of Florida will deny CPT Codes: 95782, 95783, 95808, 95810 or 95811 (Polysomnography) when a face-to-face E/M service has not been billed for the same date of service or in the previous year by any provider.
Radiation Oncology Policy-Intensity Modulated Radiotherapy (IMRT) Per our policy, which is based on the American Society for Radiation Oncology, Intensity modulated radiotherapy [IMRT] plan) should only be billed once per treatment course, even if there is a planned "cone down" treatment feature or change in field size. Aetna Better Health of Florida will deny intensity modulated radiation therapy (IMRT) when billed and an IMRT plan (77301) has been billed two weeks prior or two weeks after the IMRT date of service and the primary diagnosis is the same as any diagnosis on the IMRT planning claim line.

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Laboratory/Pathology/Genetic Testing New Policy

Please review the following new policies:

- Molecular pathology procedure, Level 7 is considered experimental and investigational.
- Genetic testing for long QT syndrome is appropriate for members with a prolonged QT interval on resting electrocardiogram without an identifiable external cause for QTc prolongation and with 1st-degree blood relatives (full-siblings, parents, offspring) with a defined LQT mutation.
- Androgen receptor gene sequence analysis for AIS is medically necessary for the following indications: exhibits signs or symptoms of AIS; Carrier screening of female reproductive partner planning a pregnancy and has family history of AIS; Prenatal testing in the offspring of the biological parent with confirmed AR mutation.
- Androgen receptor gene sequence analysis for Kennedy Disease (Spinal and Bulbar Muscular Atrophy (SBMA)) is considered appropriate.
- CSTB (cystatin B) gene testing for EPM1 (Unverricht-Lundborg disease) is appropriate for members with exhibited signs or symptoms of EPM1 or carrier screening of couples planning a pregnancy where there is family history of EPM1 or one of the partners is a known carrier of a CSTB mutation.
- Genetic testing of the TGFBI (transforming growth factor, beta-induced) gene is appropriate for members where corneal dystrophy is suspected or for members when a parent affected with corneal dystrophy or one of the partners is a known carrier of a TGFBI mutation.
- PABPN1 gene testing for OPMD (Oculopharyngeal Muscular Dystrophy) is appropriate for members with exhibited signs or symptoms of OPMD or for carrier screening of couples planning a pregnancy when one of the partners has PABPN1 is a known carrier of a PABN1 mutation.

Nail Biopsy Procedure Policy

Per our new policy surgical pathology for nail biopsy specimen must be reported on the same date of service as the nail biopsy procedure.

If you have any questions, please call our Provider Relations Department at 1-800-441-5501 (Medicaid/Healthy Kids) or 1-844-645-7371 (LTC).