Aetna Better Health® of Kansas
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Aetna Better Health® of Kansas
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 communication of upcoming new policies.

Effective for dates of service beginning August 25, 2020

Diagnosis Code Guideline Policies

Diagnosis Specificity - providers should make certain when assigning and ICD-10 code to a service that the provider must code the ICD-10 code to the highest level of specificity.

For example, if the highest-level highest level of specificity is a diagnosis code with 4 digits, a diagnosis code containing 4 digits must be used when submitting the claim.

Invalid diagnosis codes are defined as codes submitted by a provider that cannot be correlated to a diagnosis code that was valid at any point in time. When a claim is received and all the diagnosis codes on the claim header are invalid, then the claim will be denied.

Deleted diagnosis codes are defined as diagnoses that have been valid at some point in the past but have either been deleted by the governing entity or have been modified with either greater or lesser specificity. All diagnosis codes are assigned an effective date and a termination date by the governing body. Claims received with deleted diagnosis codes will be validated against the date of service.