Aetna Better Health® of Kentucky

NETWORK NOTICE

Date:	August 27, 2024
To:	All Network Providers
From:	Provider Experience
Subject:	Updated Claim Policy Edits
Document ID	Aetna-1949

NEW POLICY UPDATES
CLINICAL PAYMENT, CODING AND POLICY CHANGES

Aetna Better Health of Kentucky regularly augments 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 below the upcoming new policies.

Effective for dates of service beginning 10/01/2024, the following Kentucky Medicaid State Policies will be implemented.

Genetic Testing Policy- Genetic Testing Panel Unbundling

According to our policy, which is based on the National Correct Coding Initiative Policy Manual and the AMA CPT Manual, genetic testing panels should be coded with the most comprehensive CPT code that describes the testing that was performed. It is inappropriate to report separate codes for individual components rather than a single comprehensive panel code.

Evaluation and Management Services Policy-Transitional Care Management (TCM) Services

According to our policy, which is based on AMA CPT Manual and CMS Policy, Transitional Care Management services are required to be reported within 14 days after discharge from a facility.

According to our policy, which is based on the AMA CPT Manual, Transitional Care Management commences upon the date of discharge and continues for the next 29 days. Therefore, it is inappropriate to report a Transitional Care Management service if a qualifying Facility Evaluation and Management service has not been reported in the previous 30 days.

According to our policy, which is based on the AMA CPT Manual, transitional care management may be reported once per patient within 29 days of discharge, and only by one provider.

Drug and Biological Policy Processing and Policy Guidelines-

Drug Wastage- According to our policy, which is based on CMS Policy, it is inappropriate for a provider to report drug wastage that equals or exceeds the lowest single dose vial size for the drug.

Multi-Use Vials- According to CMS policy and a report from the Office of Inspector General (OIG), for multi-use vials, only the amount of the drug that is administered to the patient is eligible for reimbursement. Multi-use vials are not subject to payment for discarded amounts of drugs or biological agents. For trastuzumab providers should report the patient's total dose divided by 10 mg as the number of units on the claim.

According to the report from the Office of Inspector General (OIG), claims for trastuzumab are submitted with units equaling one vial/multiple of one vial are miscoded a very high percentage of the time. Wastage for multi dose vials are not appropriate and as such should not be reimbursed

Drug and Biological Policy (F-L)- Inebilizumab (J1823) (Uplizna®)

According to our policy, which is based on the FDA-approved package insert/prescribing information and the pharmaceutical compendia, the maximum recommended daily dosage of inebilizumab for the reported condition is 300 mg (300 units of J1823).

Making it easier for you to get the help when you need it.

We want to make doing business with Aetna as easy as possible, and that includes getting in touch with us when you need support.

- Leverage the **Aetna Better Health of Kentucky provider website** for manuals and quick links.
- Visit **Availity** for real time enrollment, any claim-related reviews, eligibility, prior-authorizations, grievance and appeals and questions or inquiries.
- Visit the **ECHO payment services website** for help with electronic funds transfer (EFT) and electronic remittance (ERA) set up.
- Credentialing applications, forms, demographic updates, terminations and status updates should be sent directly to **KyProviderUpdates@aetna.com**.

Still need support?

Take advantage of our **CONTACT US WEB FORM**. This form allows you to share the right information from the start, so you don't have to spend valuable time tracking down the help you need. As an added benefit for us both, we have ensured that any request or inquiry made through this form is routed to the appropriate department.

Use this form for Demographic changes, updates or terms, new provider adds to existing group contracts, large add/change/term files, W-9 submissions and terming providers due to office closures, retirement, and leaving medical group

---

Want to speak directly to someone?

Our knowledgeable **Provider Services** and **Claims Inquiry Claims Research Staff** are ready to help.

Call **1-855-300-5528** and follow the prompts.

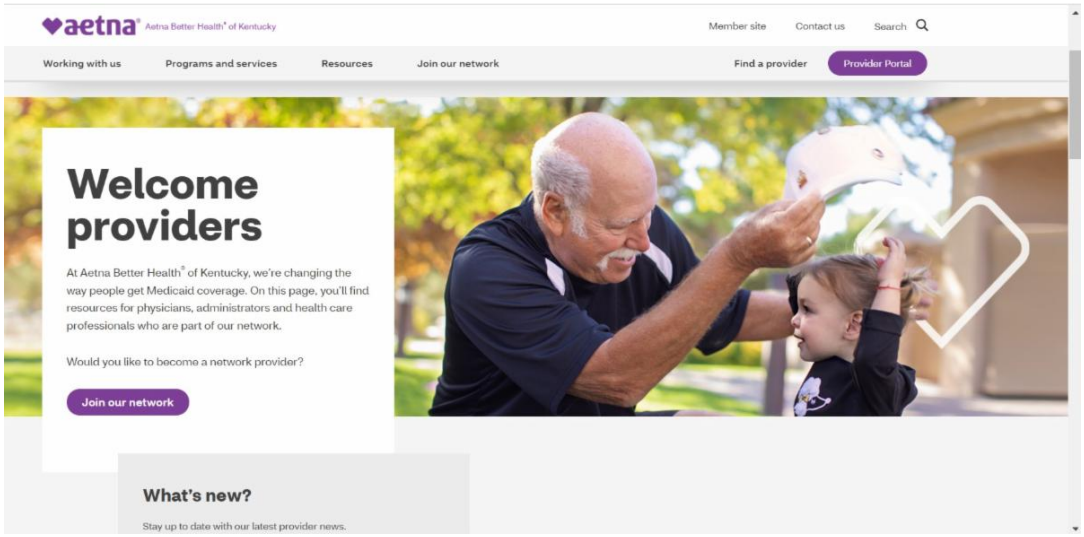
- Press * for Healthcare Provider
- Next choose: Claims, appeals status, eligibility & benefits, authorization or more options
- If you select MORE OPTIONS, then you can report fraud or abuse, talk to the Pharmacy help desk or talk to Provider services.

This department can assist with claim status, inquiries or research. pharmacy, prior authorization, EFT/ERA registration/questions, check trackers and participation status of a new load request.

Health Plan Website

The health plan website is a resource for members and providers. Providers will find information such as the member handbook, provider manual and the formulary on the health plan website

Visit the Website at: **AetnaBetterHealth.com/Kentucky**



Still have questions?

As always, do not hesitate to contact your Network Manager with any questions or comments.

Network Relations Contact Information.pdf (aetnabetterhealth.com)

Thank you for your valued partnership in caring for our Aetna Better Health of Kentucky Members.