Aetna Better Health® Kids
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Aetna Better Health® Kids
A CHIP Health Plan

AUGUST 28, 2025

CHIP POLICY GUIDELINE 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. Policy updates are based on State, Federal or standard coding requirements as noted in each policy.

Effective for dates of service beginning November 1, 2025:

Aetna Better Health Kids Policy Guidelines

Diagnosis Code Guideline, Multiple Gestation	Based on the ICD-10 Manual, certain diagnoses indicating complications to multiple gestation, maternal care, or complications of labor and delivery must also include an appropriate multiple gestation diagnosis. This policy identifies situations where any procedure or service is billed with a diagnosis designating a complication specific to multiple gestation and a diagnosis code indicating multiple gestation is not also present.
Ineligible NPI	This policy identifies situations when any service is billed by a DME supplier, and both the referring and ordering National Provider Identifier (NPI) are ineligible. Per CMS Policy, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier claims must contain a referring or ordering National Provider Identifier (NPI) of a provider with an eligible specialty who is enrolled in Medicare in an approved status.

NDC and Non-Specific Crosswalk	According to the Food and Drug Administration (FDA), providers are required to report National Drug Codes (NDC) with certain HCPCS codes. The NDC must match the HCPCS code being reported. This policy identifies situations in which a HCPCS drug code reported with non-specific language, such as miscellaneous, unclassified, NEC, NOS, etc. is billed with a National Drug Code (NDC) number and the NDC number does not match a non-specific HCPCS code in the NDC Crosswalk.
Duplicate Claim Logic for Drugs	This policy identifies situations when a vaccine code is billed and the same submitted code with the same submitted units has been billed on a different claim by any provider and any claim type for the same date of service. The second code received will be denied as a duplicate submission based on criteria that may include but is not limited to subscriber/member number, dependent number, date of service, procedure code, and units.