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Aetna Better Health® Kids
A CHIP Health Plan

October 28, 2026

NEW CHIP CODING AND EDITING GUIDELINE and REIMBURSEMENT UPDATE – EVALUATION and MANAGEMENT (E & M) SERVICES

Aetna Better Health of Pennsylvania implements comprehensive and robust policies and procedures to ensure alignment with Pennsylvania Department of Human Services (DHS) and to warrant that regulatory standards are met.

Aetna Better Health of Pennsylvania administrative policies & procedures are intended to provide a general reference for claims filing, coding, documentation guidelines and administrative functions within Aetna Better Health of Pennsylvania.

Reimbursement of reported services is subject to member benefit, eligibility on date of service, medical necessity, related plan policies and procedures, correct coding and clinical editing logic, provider contracts and all applicable plan documentation and guidelines set forth by Pennsylvania Department of Human Services (DHS). Coding methodology, regulatory requirements, industry standard claims logic, guidance from specialty organizations and other factors are considered in the development of plan policies. ABH PA retains the right to change, amend or withdraw this policy as needed, at any time.

A. Policy

This policy is provided as a guide to medical coding and editing guidelines for the appropriate reporting of Evaluation and Management (E&M) Services. This policy aligns with guidance from the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA) Current Procedural Terminology (CPT) Coding Guidelines for coding and reporting of E&M services, and applicable Pennsylvania Department of Human Services (DHS) guidance.

B. Overview

This policy outlines the coding and editing guidelines for reporting Evaluation and Management (E&M) services and applies to professional and facility claim types. E&M services describe the clinical work performed by physicians and other qualified health care professionals to assess, diagnose, and manage a patient's health condition. E&M services include coding and documentation requirements, patient status, place of service, frequency and sequencing, and global surgical package rules, appropriate modifier use, and services reported with other procedures.

E&M services include, but are not limited to:

- Examinations and evaluations
- Diagnosis and treatment services
- Conferences with or concerning patients
- Preventive pediatric and adult health supervision services
- Medical screening services
- Office and outpatient visits
- Hospital and observation services
- Consultation services
- Critical care services
- Newborn care services
- Transitional care management services

Evaluation and management services are reimbursable when the service is medically necessary, accurately coded for the patient and setting, supported by the medical record, and not duplicative of or included in another service, procedure, global surgical package, or previously reported E/M service.

Evaluation and management services are subject to applicable coding and reimbursement methodologies, including but not limited to National Correct Coding Initiative (NCCI) methodologies, Medically Unlikely Edits (MUEs), frequency limitations, global surgical package requirements, place-of-service requirements, and other coding validation methodologies.

C. Definitions

Term	Definition
Aetna Better Health of Pennsylvania (ABHPA)	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Pennsylvania Medicaid program.
American Medical Association (AMA)	A professional group that publishes research to advance public health and advocates for the interests of registered physician-members.
Centers for Medicare & Medicaid Services (CMS)	The federal agency that administers the Medicare program as well as works with the individual states to administer state Medicaid and Children's Health Insurance Programs.

Current Procedural Terminology (CPT)	A medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.
Medicaid	The state administered program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities, according to federal requirements. The program is funded jointly by states and the federal government.
Modifier	A two-digit code (numeric or alphanumeric) reported along with an applicable CPT or HCPCS code to provide greater detail about the service performed, explaining special circumstances, location, or that the service was altered without changing the code's basic definition.
National Correct Coding Initiative (NCCI)	A program administered by CMS to develop coding policies and edits used in the claims review process such as procedure to procedure and medically unlikely edits. These edits promote correct coding and ensure accurate reimbursement of claims.

D. Reimbursement Guidelines

ABH PA will reimburse Evaluation and Management (E&M) services when reported in accordance with applicable coding, documentation, and reimbursement requirements. Appropriate reporting includes, but is not limited to, the following:

New and Established Patient Services

A new patient E&M service is reimbursable when reported in accordance with CPT guidelines. A new patient is one who has not received any professional services from the same physician or other qualified health care professional of the same specialty and subspecialty within the same group practice during the previous three years. Services reported as new patient visits may be subject to review, denial, adjustment, or re-coding when claims history indicates previously reported qualifying services within the applicable lookback period.

Evaluation and Management Services Related to Surgical Procedures

E&M services performed before, on the same date as, or during the postoperative period of a procedure may not be separately reimbursable when the service is considered part of the global

surgical package. Separate reimbursement may be allowed when documentation supports that the service was significant and separately identifiable from the procedure (Modifier 25), consistent with applicable coding guidelines and modifier requirements. The appropriate modifier must be reported when required and supported by the medical record.

Multiple Evaluation and Management Services

Multiple E&M services reported for the same member on the same date of service may be subject to reimbursement limitations, service hierarchy rules, duplicate service edits, frequency limitations, or code substitutions based on coding guidelines and claims history. Multiple outpatient hospital E&M encounters reported on the same date of service may require Modifier 27 when appropriate and supported by applicable coding guidelines and documentation.

Evaluation and Management Services Reported with Other Services

An E&M service may not be separately reimbursable when reported with another diagnostic, therapeutic, preventive, monitoring, counseling, or procedural service if the E&M work is considered integral to the other service. Separate reimbursement may be allowed when documentation supports a distinct and separately identifiable service.

Place of Service

E&M services must be reported with the place of service that accurately reflects the setting in which the service was performed. Services reported with an incompatible place of service may be denied, adjusted, or recoded.

Consultation Services

Consultation services must meet applicable coding, patient status, frequency, and place-of-service requirements. Consultation services may be denied, adjusted, or recoded when another E&M service category more accurately describes the service rendered. Reimbursement may be subject to limitations based on place of service, patient status, frequency, service sequencing, and related coding requirements.

National Correct Coding Initiative (NCCI) and Unbundling

E&M services are subject to National Correct Coding Initiative (NCCI) methodologies and other coding validation methodologies. Services reported in combinations identified as component, comprehensive, mutually exclusive, incidental, or otherwise non-separately reimbursable may be denied or adjusted.

Medically Unlikely Edits (MUEs)

Units of service are subject to Medically Unlikely Edit (MUE) methodologies. Reimbursement may be limited when billed units exceed established utilization thresholds.

Specialized Evaluation and Management Services

Preventive medicine services, newborn care services, critical care services, transitional care services, discharge services, observation services, and other specialized E&M services are subject to applicable coding, documentation, frequency, and reimbursement requirements.

General Coding and Reimbursement Requirements

E&M codes, levels, units, modifiers, diagnosis codes, add-on codes, age appropriateness, and code sequencing must be reported in a manner consistent with applicable coding guidelines, reimbursement methodologies, and medical record documentation. Services that are inconsistent with coding requirements may be denied, adjusted, or recoded.

The medical record documentation is expected to support the specific CPT, HCPCS and ICD-10-CM code(s) and any applicable modifier(s) reported.

Questions? Contact our Provider Engagement department at **1-866-638-1232**.