

03/09/2026

Provider Notice: New Clinical Payment, Coding, and Policy Updates Effective June 1, 2026

Important Information for Michigan Medicaid Providers from Aetna Better Health of Michigan (ABHMI)

Aetna Better Health of Michigan (ABHMI) is committed to keeping our provider network informed of important changes to clinical, payment, and coding policies. As part of our ongoing policy review process, we are announcing several updates that will take effect for dates of service beginning June 1, 2026. Please review the following policy changes and update your billing practices accordingly to ensure compliance.

Summary of Policy Changes

Cardiac Monitoring – Modifier 25 Requirement

Evaluation and Management (E/M) services billed without modifier 25 on the same date of service as an implantable cardiac device monitoring service or acoustic cardiography service will not be separately reimbursed. Per CMS policy, E/M services must be significant and separately identifiable to qualify for reimbursement when performed on the same day as these procedures.

Self-Administered Drugs

Per CMS Policy, “Coverage for drugs that are furnished “incident to” a physician’s services can be allowed provided that the drugs are not usually self-administered by the patients who take them. The term “administered” refers only to the physical process by which the drug enters the patient’s body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the “incident to” benefit. With limited exceptions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications are considered to be usually self-administered by the patient. For the purposes of applying this exclusion, the term “usually” means more than 50 percent of the time for all Medicare beneficiaries who use the drug.

Therefore, if a drug is self-administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage.”

This policy will identify and deny self-administered drugs when billed in the following places of service as it has been determined by CMS Policy that the drug

billed is usually self-administered and is therefore not covered for the place of service reported.

01 (Pharmacy)	20 (Urgent care)	55 (Residential substance abuse facility)
03 (School)	25 (Birthing center)	57 (Non-Residential Substance Abuse Treatment Facility)
04 (Homeless shelter)	27 (Outreach site/Street)	58 (Non-residential Opioid Treatment Facility)
09 (Prison/correctional facility)	32 (Nursing facility)	66 (Programs of All-Inclusive Care for the Elderly (PACE) Center)
11 (Doctors office)	33 (Custodial care)	71 (State or local health clinic)
12 (Patients home)	49 (Independent clinic)	72 (Rural health clinic)
13 (Assisted living)	50 (Federally qualified facility)	81 (Independent laboratory)
14 (Group home)	54 (Intermediate care facility/individuals with intellectual disabilities)	
15 (Mobile unit)		
16 (Temporary lodging)		

Claims for self-administered drugs in these locations will be denied.

Medical Nutrition Therapy (MNT) – Subspecialty Limitations

In accordance with CMS policy, medical nutrition therapy will be covered only when provided by a registered dietitian, nutritional medicine provider, certified diabetic educator, registered nurse certified diabetic educator (CDE), or in a hospital setting. Services billed by other subspecialties will not be reimbursed.

Non-Invasive Vascular Studies – Requirement for Supporting Diagnosis

Simultaneous performance of arterial and venous non-invasive extremity studies during the same encounter should be rare, as the signs and symptoms of arterial and venous disease are distinct. Claims for non-invasive extremity arterial studies (CPT codes 93922-93931) billed with non-invasive extremity venous studies (CPT codes 93970-93971) must include a supporting diagnosis for either study. Claims lacking a supporting diagnosis will be denied.

We encourage all providers to review these policy changes carefully and update your billing processes accordingly.

For questions or further assistance, please contact our ABH MI Provider Experience Team at MIABHProviderNetworkMgt@AETNA.com or call Aetna Medicaid Plan 1-866-314-3784 (Option 4 then Option 6)