

Reimbursement Policy Statement Illinois Medicaid

Effective Date	Next Annual Review	Policy Number	
12/01/2020	10/01/2026	ABHIL-RP-0002	
Policy Name		Department	
Clinical & Correct Code Editing		Claims Operations Medical Payment	
Policy Type			
Medical	Administrative	Pharmacy	Reimbursement

Aetna Better Health of Illinois (ABH IL) implements comprehensive and robust policies and procedures to ensure alignment with Illinois Department of Health Care and Family Services (HFS) and to warrant that regulatory standards are met.

ABH IL reimbursement policies are intended to provide a general reference for claims filing, coding, documentation guidelines and administrative functions. Providers are ultimately responsible for submission of accurate reporting of services provided.

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 Illinois Department of Health Care and Family Services (HFS). Coding methodology, regulatory requirements, industry standard claims logic, guidance from specialty organizations and other factors are considered in the development of plan policies. ABH IL retains the right to change, amend or withdraw this policy as needed, at any time.

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A. Policy

This policy is provided as a statement of the clinical and correct code editing processes utilized by Aetna Better Health of Illinois. This policy adheres to Illinois Health and Family Services guidelines and applies to professional, outpatient facility and ambulatory surgery center claims.

B. Overview

Aetna Better Health of Illinois collaborates with industry leaders using HIPAA-compliant code editing software products for front-end automation of correct- code editing to detect coding irregularities, conflicts, or errors for professional, outpatient facility and ambulatory surgery center claims to adhere to Illinois Health and Family Services guidelines, accepted national industry standards, Federal and state laws, rules, and regulations.

C. Definitions

Term	Definition
Aetna Better Health of Illinois (ABHIL)	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Illinois 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.
Healthcare Common Procedure Coding System (HCPCS)	Level II of the HCPCS is a standardized coding system maintained by the Centers for Medicare & Medicaid Services (CMS) that is used primarily to identify products, supplies, and services not included in the CPT codes, such as Ambulance Services, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) when used outside a physician's office. Level II HCPCS codes were established for submitting claims for items and/ or services not addressed in other existing code sets.



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Illinois Department of Health Care and Family Services (HFS)	The Department of Healthcare and Family Services administers health insurance programs for children, pregnant women, and adults who are residents of Illinois.
International Statistical Classification of Diseases (ICD-10-CM)	The 10th revision of the (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
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.
Medicare	Medicare is a health insurance program for: people aged sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
Medically Unlikely Edits (MUE's)	Code edits maintained by the NCCI program that designates the number of units of a CPT or HCPCS code that can be reported for a single patient on a single date of service under most circumstances. Not all HCPCS/CPT codes have an MUE designated.
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.
Procedure-to-Procedure (PTP) Edits	Code edits maintained by the NCCI program that designates CPT and/ or HCPCS code pairs that should not be reported or reimbursed together for a single patient on a single date of service. Commonly referred to as Column 1 & Column 2 codes, these edits will also usually indicate if a code combination can be reported with the use of a scenario supported modifier.



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Provider	A licensed or certified professional who provides medical or behavioral healthcare services as well as institutions or organizations that provide services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.
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D. Reimbursement Guidelines

The HIPAA-compliant code editing software utilized by ABHIL audits a claim utilizing current and historical claim information and will make a recommendation known as an “edit” when a provider does not adhere to correct coding and/or Illinois Health and Family Services (HFS) guidelines. The various code editing utilized by ABHIL include:

- **ClaimsXten**
Real time rule-based software application that edits submitted claims for adherence to medical coverage policies, reimbursement coverage policies, benefit plans, and industry standard coding practices based on Illinois Health and Family Services State Guidelines, Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) guidelines
- **Payment Policy Management**
Software application that edits submitted claims for adherence to medical coverage policies, reimbursement coverage policies, benefit plans, and industry-standard coding practices based on Illinois Health & Family Services State Guidelines, Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) guidelines. Payment Policy Management offers claims editing solutions that validate, identify and review claims to comprehensively address Fraud Waste and Abuse.
- **Coding Validation**
Coding validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. Evaluates the correct use of coding modifiers with certain types of edits
 - For example, clinicians review claims billed with modifiers -25 and -59 for clinical circumstances which justify separate reimbursement for the service performed.

Code editing software is updated as needed to account for coding changes such as incorporating new codes, changes to code definitions and changes to rules used to support edit logic. Edit logic can be based on the several of the following sources (listed in no particular order):

- Illinois Health & Family Services State Guidelines- Takes precedence over all other editing sources
- Aetna Clinical Policy Bulletins (CPBs)
- American Medical Association (AMA) standards and published resources



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- Centers for Medicare & Medicaid Services (CMS) including Local Coverage Determinations (LCD) and National Coverage Determinations (NCD)
- CPT Coding Manual, Code Definitions and coding guidelines
- HCPCS Coding Manual, Code Definitions and coding guidelines
- ICD-10-CM Coding Manual, Code Definitions and coding guidelines
- National Correct Coding Initiative (NCCI)
- Professional Specialty Society or Association recommendations

E. Codes/Condition of Coverage
N/A

F. Frequently Asked Questions
N/A

G. Review/Revision Date

Action	Date	Comments
Review	01/08/2026	Policy template updated- Addition of PTP edit & Modifier definition; update to edit logic sources; re-wording for clarity- no other content changes
Effective Date	12/01/2020	

H. Resources
N/A