

Reimbursement Policy Statement Illinois Medicaid

Effective Date	Next Annual Review	Policy Number	
11/01/2023	03/01/2027	ABHIL-RP-0003	
Policy Name		Department	
Diagnosis Code Guidelines		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 guide to medical coding and editing guidelines for the appropriate reporting of valid ICD-10-CM diagnosis codes. This policy aligns with guidance from the Centers for Medicare & Medicaid Services (CMS) and ICD-10-CM Coding Guidelines for coding and reporting of diseases, conditions, symptoms, or reasons for care as well as Illinois Department of Health Care and Family Services (HFS) guidance.

B. Overview

This policy outlines the coding and editing guidelines for reporting of valid ICD-10-CM diagnosis codes. These codes provide detailed information about a patient's condition and support clinical documentation, reporting, and reimbursement. Claims submitted for services or procedures are required to include valid diagnosis codes that are reported to the highest level of specificity. This policy applies to all professional and facility claim types.

Invalid Diagnosis Codes

An invalid diagnosis code is one that does not correspond to a disease, condition, symptom, or reasons for care that is listed in the ICD-10-CM code set as effective on the date of service reported. Any claim that reports a diagnosis code that can be considered invalid will be denied.

Health Services for Specific Procedures and Treatments

Any procedure or treatment that is not carried out should be reported with the applicable ICD-10-CM code. Procedures or treatments that are not carried out due to the patient's decision to not move forward with services will be denied.

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.
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.



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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).

D. Reimbursement Guidelines

ABH IL will only reimburse for services and/ or procedures when submitted with ICD-10-CM diagnosis codes that are appropriately reported. Appropriate reporting includes

- Diagnosis codes reported are coded to the highest level of specificity and considered valid on the date of service reported

Claims that are submitted will be denied when

- Diagnosis codes are not reported to the highest level of specificity or are not valid on the date of service
- Procedures or treatments that are not carried out due to the patient’s decision to not move forward are correctly reported using the applicable ICD-10-CM code

The medical record documentation is expected to support the specific CPT, HCPCS, ICD-10-CM codes and any applicable modifiers reported.

E. Codes/Condition of Coverage

Applicable Health Services for Specific Procedures and Treatments ICD-10-CM codes

Z53.1	Procedure and treatment not carried out because of patient's decision for reasons of belief and group pressure
Z53.2X	Procedure and treatment not carried out because of patient’s decision for other and unspecified reasons

F. Frequently Asked Questions

N/A

G. Review/Revision Date

Action	Date	Comments
Review	03/20/2026	Policy template updated- no other content changes
Effective Date	11/01/2023	

H. Resources

1. American Medical Association. *ICD-10-CM 2026 the Complete Official Codebook, AMA; 2025.*