

## Reimbursement Policy Statement Illinois Medicaid

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|--|---------------------------|--|----------------------|
| <b>Effective Date</b>                  | <b>Next Annual Review</b> | <b>Policy Number</b>                     |                      |
| <b>05/01/2026</b>                      | <b>03/15/2027</b>         | <b>ABHIL-RP-0025</b>                     |                      |
| <b>Policy Name</b>                     |                           | <b>Department</b>                        |                      |
| <b>Physician Administered Services</b> |                           | <b>Claims Operations Medical Payment</b> |                      |
| <b>Policy Type</b>                     |                           |  |                      |
| <b>Medical</b>                         | <b>Administrative</b>     | <b>Pharmacy</b>                          | <b>Reimbursement</b> |

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 physician administered services. This policy aligns with guidance from the Centers for Medicare & Medicaid Services (CMS), Illinois Department of Health Care and Family Services guidance as well as with AMA CPT and HCPCS Coding Guidelines.

**B. Overview**

This policy outlines the coding and editing guidelines for reporting of physician administered services. Certain physician administered services are assigned a maximum amount of units that can be reported per day. These maximum units are assigned and published by HFS and can be found on the Practitioner Fee Schedule. Maximum reportable units per day are listed for each CPT and/ or HCPCS code under the “Max Qty” column of the fee schedule.

ABH IL follows the unit limits set by HFS when processing claims. Providers are encouraged to use the HFS Practitioner Fee Schedule as guidance when submitting claims for physician- administered services. This policy applies to all professional claim types.

**C. Definitions**

| <b>Term</b>                                    | <b>Definition</b>  |
|--|--|
| 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. |



Aetna Better Health® of Illinois

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|--|--|
| Healthcare Common Procedure Coding System (HCPCS)            | Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT code set. Examples include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Level II HCPCS codes were established to allow these products, supplies and services to be reported for reimbursement. |
| 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.   |
| 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).  |
| 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.  |
| Physician Administered Services                              | Services or treatments that must be given by a physician or qualified health care professional in a clinical setting and cannot be safely self-administered by the patient   |

**D. Reimbursement Guidelines**

ABH IL will only reimburse for physician administered services when appropriately reported.

Appropriate reporting includes

- Reporting only up to the unit limits set by HFS for CPT and/ or HCPCS codes.
- For drugs that are not administered and are discarded, the HCPCS code must be reported with the JW modifier. Discarded units billed with the JW modifier are excluded from unit limits.

Claims that are submitted will be denied when

- CPT and/ or HCPCS codes are reported with units that exceed the unit limits set by HFS

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

**E. Codes/Condition of Coverage**

Modifier

|    |   |
|----|---|
| JW | Drug amount discarded/not administered to any patient |
|----|---|

**F. Frequently Asked Questions**

N/A

**G. Review/Revision Date**

| Action         | Date       | Comments |
|----------------|------------|----------|
| Effective Date | 05/01/2026 |          |

**H. Resources**

1. American Medical Association. *CPT Professional Edition 2026, AMA; 2025.*
2. American Medical Association. *HCPCS Level II Professional 2026, AMA; 2025.*
3. Illinois Department of Healthcare and Family Services. *Practitioner Fee Schedule; 2026.*  
<https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/practitioner.html>