

## Reimbursement Policy Statement Illinois Medicaid

<b>Effective Date</b>	<b>Next Annual Review</b>	<b>Policy Number</b>	
12/01/2020	04/01/2027	ABHIL-RP-0028	
<b>Policy Name</b>		<b>Department</b>	
Evaluation & Management (E&M) Services		Claims Operations Medical Payment	
<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 evaluation & management (E&M) services. This policy aligns with guidance from the Centers for Medicare & Medicaid Services (CMS), AMA CPT Coding Guidelines for coding and reporting of evaluation & management (E&M) services 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 evaluation & management (E&M) services and applies to all 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. These services focus on a provider's cognitive and decision-making activities rather than on the performance of a specific procedure or test. According to CMS guidelines, an E&M service can be reported no more than once per day by the same provider, within the same specialty.

### **New Patient Visits**

A new patient is defined as a person who has not received any professional services from the physician or another physician of the same specialty in the same provider group within the past three years. New patient E&M services will be denied if any face-to-face service has previously been reported by the same physician or a physician group practice (with the same specialty and subspecialty) within the last three years.

For services provided in a facility setting, a new patient is one who has not been registered as an inpatient or outpatient of the hospital within the past three years. New patient E&M services will be denied if any service has been previously reported within the last three years utilizing any of the applicable type of bill codes specified in this policy or has been reported by the same facility.

### **Problem Oriented & Preventative Visits**

A preventive medicine visit is a scheduled encounter focused on maintaining health and preventing disease in an asymptomatic patient whereas a problem-oriented visit is focused on the evaluation and management of a specific medical problem, symptom, or condition. According to AMA CPT coding guidelines, it is inappropriate for a specific provider to report more than one E&M service on the same day.

In instances where a patient is seen for a preventative visit, but a problem or abnormality emerges, taking care of a problem or abnormality is considered part the global service when a preventative medicine service is performed. If the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the preventative medicine E&M service should be reported with the 25-modifier appended to indicate that a significant, separately identifiable E&M service occurred.



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**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.
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.
Type of Bill (TOB) Code	A four-digit numeric code reported on institutional claims (UB-04 / CMS-1450) that classifies the type of facility submitting a claim, the type of care provided, and the billing sequence for the episode of care.

**D. Reimbursement Guidelines**

ABH IL will only reimburse for E&M services when appropriately reported. Appropriate reporting includes

- No more than one unit per E&M code is reported per date of service
- New patient visits are not reported by a physician or physician group that also reported a face-to-face visit within last three years
- New patient visits are not reported by a facility where the patient was registered for an inpatient or outpatient service within last three years
- Problem-oriented E&M services are reported along with preventative services, and the 25-modifier is appended to indicate a significant and separately identifiable service was provided

Claims that are submitted will be denied when

- More than one unit per E&M code is reported per date of service
- New patient visits are reported by a physician or physician group that also reported a face-to-face visit within last three years
- New patient visits are reported by a facility where the patient was registered for an inpatient or outpatient service within last three years
- Problem-oriented E&M services are reported along with preventative services, and the 25-modifier is not appended, and a significant and separately identifiable service was not provided

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

**E. Codes/Condition of Coverage**

Applicable Modifier

25	Significant, separately identifiable evaluation and management (E&M) service by the same physician or other qualified health care professional on the same day of the procedure or other service
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Applicable Type of Bill Codes

012X	Hospital inpatient part B
013X	Hospital outpatient
014X	Hospital other part B
071X	Rural health clinic
072X	Clinic hospital based or independent renal dialysis center
073X	Clinic freestanding
079X	Clinic- other



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## F. Frequently Asked Questions

N/A

## G. Review/Revision Date

Action	Date	Comments
Revision	04/01/2026	Previous policies merged to combine related content and new policy title; Update policy template
Effective Date	12/01/2020	New Patient Visit Frequency & Problem Oriented Visits with Preventative Visits- previous policy documents

## H. Resources

1. American Medical Association. *CPT Professional Edition 2026, AMA*; 2025.
2. American Medical Association. *ICD-10-CM 2026 the Complete Official Codebook, AMA*; 2025.
3. Centers for Medicare & Medicaid Services. (n.d.). *Medicare claims processing manual* (Pub. 100-04, Chapter 12, § 30.6.7(A), Payment for office or other outpatient evaluation and management (E/M) visits). <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf>