Aetna Better Health® of Illinois
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aetna®

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Aetna Better Health® of Illinois

New policy updates: Clinical, payment and coding policy changes

At Aetna Better Health® of Illinois, we regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. Please see upcoming new policies as shown below, effective for dates of service beginning 6/1/2024:

Medicaid - Illinois State Policy-

-Modifier Policy - Unrelated Procedure/Service by the Same Physician During the Postop Period
According to our policy, which is based on the AMA Coding With Modifiers Manual and Illinois Medicaid Policy, modifier 79 is used to indicate that the performance of a procedure or service during the post-operative period was unrelated to the original procedure. The unrelated procedure must be reported during the post-operative period of the original service.

-Modifier Policy - Return to the OR for a Related Procedure During the Postop Period
According to our policy, which is based on the AMA Coding with Modifiers Manual and Illinois Medicaid Policy, modifier 78 is used to indicate that subsequent procedure is related (i.e., complication) to the initial procedure and requires the use of an operating room. The related procedure must be reported during the post-operative period of the original service.

-Non-Physician Practitioners (NPPs) Billing Major Surgical Procedures
According to our policy, which is based on CMS and Illinois Medicaid Policy, major surgical procedures (30-day global period) are generally not a covered service when reported by a non-physician practitioner.

-Split Surgical Care Policy - Split Surgical Care Modifiers
According to our policy, which is based on CMS Policy and Illinois Medicaid Policy, modifiers 54 (Surgical care only), 55 (Postoperative management only), and 56 (Preoperative management only) should only be appended to procedure codes with a 30-day global period.

-Split Surgical Care Policy - Same Procedure in the Post-Operative Period
According to CMS Policy and Illinois Medicaid guidelines, when a provider bills a code for a major surgical procedure in the office setting and the same procedure has been billed globally by any provider in the previous 30 days, it is assumed that the second service represents post-operative care for the earlier service.

CMS National Coverage Determinations (NCD) Policy-Lung Cancer Screening with Low Dose Computed Tomography (LDCT)
According to our policy, which is based on CMS Policy, services related to screening for lung cancer with low dose computed tomography (LDCT) are only covered for certain diagnoses.

According to our policy, which is based on CMS Policy, screening for lung cancer with low dose computed tomography (LDCT) should not be performed more than once within a 12-month period (11 full months have elapsed).

According to our policy, which is based on CMS Policy, services related to screening for lung cancer with low dose computed tomography (LDCT) are only covered for patients who are 55 to 77 years old.

Gastroenterology Policy-Endoscopic Retrograde Cholangiopancreatography (ERCP)
According to our policy, when performing an ERCP and stone extraction, it is common to perform a papillotomy, a balloon sweep of the duct, removal of the stone, i.e., removal of a foreign body, and place a stent on the same day. Therefore, these procedures should not be billed or reported separately.

Questions?

Please contact your assigned Provider Relations representative with any questions.