Aetna Better Health® of Illinois
PO Box 818031, MC F661
Cleveland, OH 44181-8031

March 9, 2026

Aetna Better Health® of Illinois

Policy updates effective May 1, 2026

We regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see the below highlighting upcoming new policies.

Effective for dates of service beginning **May 1, 2026**.

Illinois Medicaid-Policy Guidelines

EM Services with Cardiac Monitoring

This policy identifies situations when an Evaluation and Management service is billed without modifier 25 on the same date of service as an implantable cardiac device monitoring service or an acoustic cardiography service.

According to CMS Policy, the evaluation and management (EM) service is not separately payable when performed on the same date of service as the implantable cardiac device monitoring service or acoustic cardiography, unless the EM service is reported as being significant and separately identifiable.

Self-Administered Drugs

Per CMS Policy, "Coverage for drugs that are furnished "incident to" a physician's services can be allowed provided that the drugs are not usually self-administered by the patients who take them. The term "administered" refers only to the physical process by which the drug enters the patient's body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the "incident to" benefit. With limited exceptions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications are considered to be usually self-administered by the patient. For the purposes of applying this exclusion, the term "usually" means more than 50 percent of the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is self-administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage."

This policy will identify and deny self-administered drugs when billed in the following places of service as it has been determined by CMS Policy that the drug billed is usually self-administered and is therefore not covered for the place of service reported.

01 (Pharmacy) 03 (School) 04 (Homeless shelter) 09 (Prison/correctional facility) 11 (Doctors office) 12 (Patients home) 13 (Assisted living) 14 (Group home) 15 (Mobile unit) 16 (Temporary lodging) 20 (Urgent care) 25 (Birthing center) 27 (Outreach site/Street)	32 (Nursing facility) 33 (Custodial care) 49 (Independent clinic) 50 (Federally qualified facility) 54 (Intermediate care facility/individuals with intellectual disabilities) 55 (Residential substance abuse facility) 57 (Non-Residential Substance Abuse Treatment Facility) 58 (Non-residential Opioid Treatment Facility) 66 (Programs of All-Inclusive Care for the Elderly (PACE) Center) 71 (State or local health clinic) 72 (Rural health clinic) 81 (Independent laboratory)

Radiology Services Outside of Office
This policy identifies situations when a radiology service is billed with place of service 12 (Home), 13 (Assisted living facility), 27(Outreach site/street), 31 (Skilled nursing facility), or 32 (Nursing facility), without modifier 26 and without an x-ray equipment transportation code.

According to CMS Policy, when a provider bills for a radiology service performed in a home or nursing/assisted living facility, the procedure or service should be reported with modifier 26 to indicate the professional component.

Intracranial and Extracranial Imaging for Simple Syncope
This policy identifies situations when an intracranial or extracranial imaging code is billed and the only diagnosis on the claim is ICD-10 code R55 (Syncope and collapse).

According to the American College of Emergency Physicians, American Heart Association/American College of Cardiology Foundation, American College of Radiology and American Academy of Family Physicians, advanced diagnostic imaging of the brain (CT, MRI) should not be performed routinely for evaluation of syncope, in the absence of related neurologic signs and symptoms.

Required Diagnoses for Non-Invasive Diagnostic Studies
This policy identifies situations when 93880 or 93882 is billed in Place of Service 11 (Office) for a patient 18 years of age or older and a carotid artery stenosis symptom diagnosis is not present on the claim.

According to the U.S. Preventive Services Task Force, it is not appropriate to screen for carotid artery stenosis in asymptomatic adult patients.

Non-Invasive Vascular Studies Missing a Supporting Diagnosis
Based on CMS Policy, because the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the simultaneous performance of arterial and venous studies during the same encounter should be rare.

This policy identifies situations where a non-invasive extremity arterial study (93922-93931) is billed with a non-invasive extremity venous study (93970-93971) and a supporting diagnosis for either study is not present.