Aetna Better Health® of Illinois
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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

Chiropractic Service

This policy identifies situations when 98943 (Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions) is billed.

According to Illinois State Medicaid Guidelines, chiropractic services are limited to the treatment of the spine by manual manipulation to correct a subluxation of the spine.

Age Restrictions for Adult Disposable Incontinence Product

This policy identifies situations when T4543 (Disposable incontinence product, brief/diaper, bariatric, each) is billed and the patient is less than 12 years of age.

According to Illinois Medicaid Guidelines, this bariatric protective brief/diaper disposable incontinence product is not covered for patients less than 12 years of age.

Evaluation and Management with 30-Day Global Surgeries

These policies identify situations when an evaluation and management service is performed within the global period of a 30-Day Major Surgical Procedure.

Situations may include but are not limited to:

- Evaluation and Management services when performed the day prior to a 30-day medical or surgical service.
    - According to CMS Policy and Illinois State Medicaid Guidelines, the Global Surgical Package includes Evaluation and Management (E/M) visits rendered the day prior to a major surgical procedure. Therefore, when an E/M visit is reported the day prior to the major surgical procedure, it will be bundled as part of the global surgical fee.
- Evaluation and Management services performed within 30 postoperative days of a 30-day medical or surgical service.

    - According to CMS Policy and Illinois Medicaid Policy, the Global Surgical Package includes follow-up evaluation and management visits during the postoperative period of the surgery that are related to recovery from the surgery. Therefore, when an evaluation and management visit is reported within 30 days of the major surgical procedure, it will be bundled as part of the global surgical fee.
- Evaluation and Management services performed within 30 postoperative days of a 30-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 30-day medical or surgical service.
    - According to CMS Policy and Illinois State Medicaid Guidelines, the Global Surgical Package includes follow-up Evaluation and Management (E/M) visits during the postoperative period of the surgery that are related to recovery from the surgery. Therefore, when an E/M visit is reported within 30 days of a major surgical procedure, it will be bundled as part of the global surgical fee.
- Evaluation and Management services performed within 30 postoperative days of a 30-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
    - According to CMS Policy and Illinois State Medicaid Guidelines, the Global Surgical Package includes follow-up Evaluation and Management (E/M) visits during the postoperative period of the surgery that are related to recovery from the surgery. Therefore, when an E/M visit is reported within 30 days of a major surgical procedure, it will be bundled as part of the global surgical fee.
- Evaluation and Management services when performed the same day as a 30-day medical or surgical service.
    - According to CMS Policy and Illinois State Medicaid Guidelines, the Global Surgical Package includes Evaluation and Management (E/M) visits rendered the same day as a major surgical procedure. Therefore, when an E/M visit is reported the same day as a major surgical procedure, it will be bundled as part of the global surgical fee.
- Evaluation and Management services when performed the same day as a 30-day medical or surgical service when billed by the same Provider ID, regardless of Tax ID and Specialty.
    - According to CMS Policy and Illinois State Medicaid Guidelines, the Global Surgical Package includes Evaluation and Management (E/M) visits rendered the same day as a major surgical procedure. Therefore, when an E/M visit is reported the same day as a major surgical procedure, it will be bundled as part of the global surgical fee.

Evaluation and Management (E/M) Service with Modifier 24 During Postoperative Period
Management (E/M) services billed during the postoperative period with modifier 24 without sufficient indication that the visit is unrelated to the surgery. Modifier 24 is intended for use with services that are absolutely unrelated to the surgery; it is not intended to be used for the medical management of a patient by the surgeon following surgery.

This policy identifies situations in which an E/M service is billed within 30 days of a major surgical procedure for the same diagnosis.

Evaluation and Management (E/M) Service with Modifier 25 on the Same Day as a Procedure
Based on CMS Policy and Illinois Medicaid Policy, when an Evaluation and Management (E/M) service is billed with modifier 25 on the same day as a procedure with a 30-day postoperative period, the E/M service is payable only if it is significant and separately identifiable. Therefore, if the patient has had a previous face-to-face visit for the same or similar diagnosis as the E/M service with modifier 25 and the procedure, then the E/M service billed with modifier 25 will be denied.

This policy identifies situations in which an E/M service is billed on the same day as a procedure with a 30-day postoperative period and a previous face-to-face service has been reported with a matching primary diagnosis.

30-Day Surgical Procedures Reported During the Postoperative Period of a Prior Procedure
Based on CMS Policy and Illinois Medicaid Policy, separate payment for additional procedure(s) with a global surgery fee period during the postoperative period of a prior procedure must be billed with an appropriate modifier designating the reason for the second procedure.

This policy identifies situations in which a 30-day procedure is reported during the postoperative period of a prior procedure.

30-Day Surgical Procedures During Postoperative Period of a Prior 30-Day Surgical Procedure
Based on CMS Policy and Illinois State Medicaid Guidelines, separate payment for additional procedure(s) with a global surgery fee period during the postoperative period of a prior procedure must be reported with an appropriate modifier designating the reason for the second procedure.

This policy identifies situations where an additional surgical service is reported by the same provider within 30 days of a postoperative period of a 30-day surgical procedure.

Services During Postoperative Period of a 30-Day Surgical Procedure
Based on CMS Policy and Illinois State Medicaid Guidelines, the performance of a related procedure within the global period of a major procedure is included in the global services for the major procedure. Therefore, related post-operative procedures should not be billed separately.

This policy identifies situations where a service typically considered part of a 30-day surgical procedure is reported within 30 days of a 30-day surgical procedure.

Frequency Restrictions for Group Psychotherapy Services
This policy identifies situations when 90849 or 90853 (Group psychotherapy service) are billed, in any combination, more than two visits in a seven-day period, by any provider, unless reported in Place of Service 53 (Community Mental Health Center).

According to Illinois Medicaid Guidelines, group psychotherapy services are limited for each participant to two sessions in a seven-day period.

Physician Administered Services Maximum Units
This policy limits physician administered services to the daily maximum assigned units (per Illinois Medicaid Guidelines) when billed by any provider.

Age Restrictions for Prostate Cancer Screening Services
This policy identifies situations when G0102 or G0103 (Prostate Cancer Screening) is billed and the patient is less than 40 years of age.

According to Illinois Medicaid Guidelines, these prostate cancer screening procedure codes are covered only for patients 40 years of age or older.

Questions?

If you need assistance or have any questions, please contact your **Provider Relations Representative** or email us at **ABHILProviderRelations@AETNA.com.**