Aetna Better Health® of Illinois

Reimbursement Policy Statement Illinois Medicaid

Effective Date	Next Annual Review	Policy Number
09/01/2022	09/01/2027	ABHIL-RP-0036

Policy Name	Department
Device & Supplies	Claims Operations Medical Payment

Policy Type			
Medical	Administrative	Pharmacy	Reimbursement

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.

CONTENTS OF POLICY:

Reimbursement Policy Statement 1
Table of Contents 1
A. Policy 2
B. Overview 2
C. Definitions 2
D. Reimbursement Guidelines 4
E. Codes/Conditions of Coverage 4
F. Frequently Asked Questions 4
G. Review/Revision History 4
H. Resources 5

Aetna Better Health® of Illinois

A. Policy

This policy is provided as a guide to medical coding and editing guidelines for the appropriate reporting of various devices and/ or supplies provided integral to surgical procedures. 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 Healthcare Common Procedure Coding System (HCPCS) Coding Guidelines for coding and reporting of devices and supplies utilized as part of surgical procedures.

B. Overview

This policy outlines the coding and editing guidelines for reporting various devices and/ or supplies provided integral to surgical procedures and applies to all professional and facility claim types.

Ambulatory Surgery Centers (ASC)

Certain devices that are provided integral to a covered ASC procedure can be reported separately from the procedure. The device code will be denied when reported without an ASC surgical procedure reported on the same date of service for claims submitted with the place of service (POS) code 24- Ambulatory Surgical Center.

Implant Devices

Surgical procedures that require one or more implant devices must be reported with the applicable code for the implant device required for the specific procedure. A device-dependent surgical procedure reported without the applicable device code will be denied. Procedures reported with one of the following modifiers will bypass this requirement.

Modifier 52- Reduced Procedure	**Modifier 73**- Discontinued procedure prior to the administration of anesthesia	**Modifier 74**- Discontinued procedure after the administration of anesthesia

Implantable surgical devices provided integral to a surgical procedure are expected to be reported along with the applicable code for the procedure. Implant devices reported without the associated surgical procedure will be denied when reported with a hospital setting type of bill code that does not indicate an inpatient level of care (TOB codes 012X).

C. Definitions

Term	Definition
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.
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.
Place of Service Code (POS)	A two-digit numeric code used on professional healthcare claims to identify the setting in which a service was furnished. The POS code set is maintained by CMS.
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 devices and/ or supplies related to surgical procedures when appropriately reported. Appropriate reporting includes

- Devices and/ or supplies provided as part of a procedure conducted in an ASC setting (POS 24) are reported with the corresponding procedure on the same date of service
- Surgical procedures that require the use of an implantable device are reported with the appropriate device code
- Surgical procedures that require the use of an implantable device not reported with the appropriate device code are appended with either modifier 52, 73 or 74
- Implantable devices provided in the hospital setting are reported with the associated surgical procedure for all bill types except TOB code 012X

Claims that are submitted will be denied when

- Devices and/ or supplies provided as part of a procedure conducted in an ASC setting (POS 24) are not reported with the corresponding procedure on the same date of service
- Surgical procedures that require the use of an implantable device are not reported with the appropriate device code
- Surgical procedures that require the use of an implantable device not reported with the appropriate device are not appended with either modifier 52, 73 or 74
- Implantable devices provided in the hospital setting are not reported with the associated surgical procedure for all bill types except TOB code 012X

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

E. Codes/Condition of Coverage

N/A

F. Frequently Asked Questions

N/A

G. Review/Revision Date

Action	Date	Comments
Revision	07/09/2026	Annual Review; policy template updated- No other content changes
Revision	08/27/2025	Annual Review- No content changes
Effective Date	09/01/2022	

H. Resources

1. American Medical Association. *CPT Professional Edition 2025, AMA;* 2024.
2. Centers for Medicare & Medicaid Services. (2026, May 28). *Medicare claims processing manual (Pub. 100-04), Chapter 4: Part B hospital (including inpatient hospital Part B and OPPS)*. U.S. Department of Health and Human Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf
3. Centers for Medicare & Medicaid Services. (2026, June 24). *Medicare claims processing manual (Pub. 100-04), Chapter 14: Ambulatory surgical centers*. U.S. Department of Health and Human Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c14.pdf