

Reimbursement Policy Statement Illinois Medicaid

Effective Date	Next Annual Review	Policy Number	
11/01/2023	11/01/2026	ABHIL-RP-0021	
Policy Name		Department	
Global Surgery		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.

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A. Policy

This policy is provided as a guide to medical coding and editing guidelines for the appropriate reporting of surgical procedures and related services that can be considered as part of the global surgical package. 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 with AMA CPT Coding Guidelines for coding and reporting of surgical procedures and evaluation & management services.

B. Overview

This policy outlines the coding and editing guidelines for reporting services that can be considered as part of the global surgical package. A Global Surgical Package is a single reimbursement that includes all necessary services normally furnished by the surgeon or provider before, during, and after a covered surgical procedure. These services are considered integral to the procedure and are not separately reimbursable when performed by the same provider, unless otherwise specified by plan policy or applicable modifiers. The Global Surgical Package applies to procedures that have a defined postoperative global period which is typically 0- day, 10- day, 30-day or 90-day periods. This policy applies to all professional claim types.

According to CMS policy as well as HFS guidelines, all supplemental medical or surgical services required of the surgeon during the postoperative period due to complications are included in the global surgical package. According to CMS policy and Illinois Medicaid guidelines, all supplemental medical or surgical services required of the surgeon during the postoperative period because of complications, which do not require additional trips to the operating room, are included in the global surgical package. Procedures with a 30-day global period, reported by any provider within the 30-day period of another procedure will be denied.

Evaluation & Management Services

Modifier 25 is used to indicate that an E&M service conducted on the same day as a surgical procedure with a 30-day global period by the same physician was significant and separately identifiable. E&M services reported with the 25 modifier on the same day as a surgical procedure with a 30-day global period will be denied if the E&M is reported with the same primary diagnosis code as the surgical procedure and the provider has reported a face-to-face service within the previous two months that also reported the same diagnosis code.

Evaluation & Management (E&M) services that occur within the global surgical period of a procedure can be considered part of the surgical package. E&M services reported on either the day prior, the same day or within the 30-day postoperative period of a 30-day global procedure will be considered bundled into the surgical package and denied when reported under the same provider ID.

Modifier 24 is used to indicate that an E&M service conducted during a 30-day postoperative period by the same physician is not related to the surgical procedure. E&M services reported within the global period of a 30-day surgical procedure will be denied if reported with the 24

modifier and the primary diagnosis reported is associated with the diagnosis reported for the procedure.

Split Surgical Care *Effective 06/01/2024*

When the components of a global surgical package are provided by more than one provider and each provider reports only the services they personally provided, it is referred to as split surgical care or shared global surgical services. The appropriate modifier (54, 55 or 56) should be appended to the service reported to indicate which component of the surgical package was provided. Per CMS guidance as well as HFS guidelines, split surgical care modifiers should only be appended to services with a 30-day global period.

When a major surgical procedure is reported as being conducted in the office place of service (POS 11) and has been reported by any provider within the previous 30 days, it is assumed that the office-based service represents post-operative care and will be denied if an appropriate split surgical care modifier is not appended.

Non-Physician Practitioners *Effective 05/01/2026*

Per CMS guidance as well as HFS guidelines, a non-physician practitioner (NPP) who conducts postoperative care in place of a surgeon within the same practice (utilizing the same tax id for reporting), will be considered the same specialty as the surgeon. E&M services reported within 30 postoperative days from a procedure with a 30-day global period, conducted by an NPP within the same practice as the surgeon will be denied when the diagnoses reported indicate either a surgical complication, aftercare or the primary diagnosis is associated with surgical procedure diagnosis.

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.



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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.
Evaluation and Management Services (E&M)	A category of CPT codes that represents the professional work and medical decision making involved in evaluating, diagnosing or managing patient care.
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.
Non-Physician Practitioners (NPP)	A licensed health care professional authorized to deliver medical services within their scope of practice without direct physician supervision, though often working in collaboration. NPP is used to commonly refer to Advanced Practice Nurses (APN) and Physician Assistants.
Surgery Indicator (M)/ 30- day surgical procedure	Specific CPT codes that are considered major surgical procedures by HFS. These procedures are indicated by the Illinois Practitioner fee schedule by the M indicator and reimbursement for these procedures includes a 30- day postoperative care.

D. Reimbursement Guidelines

ABH IL will only reimburse for services and/ or procedures occurring within the global surgery period when appropriately reported which includes

- Appropriate use of the 25 modifier for significant and separately identifiable E&M services
- Appending modifier 24 to E&M services reported within 30 days of a 30-day surgical procedure and the diagnosis code reported is unrelated to the surgical procedure effective 05/01/2026
- A 30- day surgical procedure is not reported within 30 days of another 30- day surgical procedure effective 05/01/2026

Claims that are submitted will be denied when

- Modifier 25 is not appended to an E&M service reported on the same day as a procedure with a postoperative period of 0, 10 or 90 days or the E&M service is not significant and separately identifiable
- Modifier 24 is not appended to an E&M service reported within 30 days of a 30-day surgical procedure and/ or the diagnosis code reported is related to the surgical procedure effective 05/01/2026
- An E&M service is reported the day before or within 30 days of a 30- day surgical procedure regardless of tax ID and specialty of the involved providers effective 05/01/2026
- An E&M service appended with modifier 25 is reported on the same day as a 30-day surgical procedure and the provider has reported another E&M service within the previous two- month period for the same condition effective 05/01/2026
- Services typically considered part of a 30-day surgical procedure are separately reported by the same provider that reported the procedure effective 05/01/2026

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

E. Codes/Condition of Coverage

Applicable E&M Codes

92002-92014	Ophthalmological services: medical examination and evaluation
92502	Otolaryngologic examination under general anesthesia
92504	Binocular microscopy (separate diagnostic procedure)
98000-98007	Synchronous audio-video visit for evaluation and management
98008-98015	Synchronous audio-only visit for evaluation and management
99202-99499	Evaluation and Management



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G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Applicable modifiers

24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only

F. Frequently Asked Questions

N/A

G. Review/Revision Date

Action	Date	Comments
Revision	02/24/2026	Policy template updated; guidance added as indicated on 30-day surgical procedures (effective 05/01/2026).
Revision	04/30/2026	Guidance on split surgical care added (effective 06/01/2024).
Effective Date	11/01/2023	

H. Resources

- American Medical Association. *CPT Professional Edition 2025, AMA; 2024.*
- American Medical Association. *ICD-10-CM 2025 the Complete Official Codebook, AMA; 2024.*
- Illinois Department of Healthcare and Family Services. *Practitioner Fee Schedule; 2025.*
<https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/practitioner.html>