

## Reimbursement Policy Statement Illinois Medicaid

<b>Effective Date</b>	<b>Next Annual Review</b>	<b>Policy Number</b>	
11/01/2023	05/01/2027	ABHIL-RP-0035	
<b>Policy Name</b>		<b>Department</b>	
General Surgery		Claims Operations Medical Payment	
<b>Policy Type</b>			
<b>Medical</b>	<b>Administrative</b>	<b>Pharmacy</b>	<b>Reimbursement</b>

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 various surgical procedures. This policy aligns with guidance from the Centers for Medicare & Medicaid Services (CMS), Illinois Department of Health Care and Family Services guidance, National Correct Coding Initiative (NCCI) guidance as well as with AMA CPT Coding Guidelines for coding and reporting of surgical procedures.

## B. Overview

This policy outlines the coding and editing guidelines for reporting various surgical procedures and scenarios. This policy applies to all professional and facility claim types.

### **Venous Procedures**

An injection of sclerosing solution (36465, 36466, 36470, 36471) should not exceed four visits per single vein or per multiple veins in the same leg within a three-month time frame. Therefore, billing more than four treatment sessions (or dates of service) within a three-month period will be denied.

### **Pilonidal Cyst or Sinus Procedures** *Effective 03/01/2024*

Per AMA CPT coding guidelines, applicable pilonidal cyst or sinus procedures will be denied if reported without an appropriate diagnosis code that indicates a pilonidal cyst or pilonidal sinus.

### **Decompression Procedures** *Effective 06/01/2024*

Per CMS Medicaid NCCI guidelines, stereotactic navigational procedures are usually performed to identify anatomy for precise treatments and identify vital structures to avoid. This is not necessary for a simple spinal decompression procedure, therefore 61783 will be denied if reported with simple spinal decompression codes 63001- 63053.

### **Non- Physician Practitioners** *Effective 06/01/2024*

Per CMS guidance as well as HFS guidelines, major surgical procedures (procedures with a 30-day global period) are not covered when reported by a non-physician practitioner (NPP). Reported services will be covered if the NPP's participated as an *Assistant Surgeon*, or they only provided providing preoperative and/or postoperative care. Major surgical procedures reported without the applicable modifier to indicate their involvement as an assistant surgeon will be denied.

### **Procedures Within the Post-Operative Period** *Effective 06/01/2024*

Per CMS guidance as well as HFS guidelines, when a surgical procedure is conducted either on the same date of service or within the initial procedures defined global period (0 days/ 10 days or 90 days) and requires the use of an operating room- it is considered a related procedure. A common scenario would be a procedure conducted to address a complication. Related procedures should be reported with the 78 modifier to indicate it as a subsequent and different procedure. Surgical procedures reported with the 78 modifier will be denied if a separate surgical procedure has not been reported either on the same date of service or in the previous



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days of the applicable global period. This does not apply to procedures reported by assistant surgeons, with the appropriate modifier appended.

A secondary procedure conducted within the global period of a previous procedure and the two are unrelated should be reported with the 79 modifier. Surgical procedures reported with the 79 modifier will be denied if a separate surgical procedure has not been reported either on the same date of service or in the previous days of the applicable global period. This does not apply to procedures reported by assistant surgeons, with the appropriate modifier appended.

**C. Definitions**

<b>Term</b>	<b>Definition</b>
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.
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.
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.



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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.
National Correct Coding Initiative (NCCI)	A program administered by CMS to develop coding policies and edits used in the claims review process such as procedure to procedure and medically unlikely edits. These edits promote correct coding and ensure accurate reimbursement of claims.
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.

**D. Reimbursement Guidelines**

ABH IL will only reimburse for surgical procedures when appropriately reported. Appropriate reporting includes

- Injection of sclerosing solution procedures are reported in any combination within the stated limits of 4 or less visits within a three-month timeframe by any provider
- Pilonidal cyst or pilonidal sinus procedures are reported with an appropriate diagnosis code *Effective 03/01/2024*
- Simple spinal decompression procedures are not reported with stereotactic computer assisted navigational procedures *Effective 06/01/2024*
- Related and unrelated surgical procedures that occur within the post-operative period of another period are reported with the appropriate modifier and the previous procedure has been reported *Effective 06/01/2024*
- Major surgical procedures reported by NPP's with the appropriate assistant surgeon modifier *Effective 06/01/2024*

Claims that are submitted will be denied when

- Injection of sclerosing solution procedures are reported in any combination for 5 or more visits within a three-month timeframe by any provider
- Pilonidal cyst or pilonidal sinus procedures are not reported with an appropriate diagnosis code *Effective 03/01/2024*
- Simple spinal decompression procedures are reported with stereotactic computer assisted navigational procedures *Effective 06/01/2024*
- Related and unrelated surgical procedures that occur within the post-operative period of another period are not reported with the appropriate modifier and/ or the previous procedure has not been reported *Effective 06/01/2024*
- Major surgical procedures reported by NPP's without the appropriate assistant surgeon modifier *Effective 06/01/2024*

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

**E. Codes/Condition of Coverage**

Applicable Venous Procedure codes

36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring;
36466	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg

Applicable Pilonidal Cyst/ Sinus Procedure codes *Effective 03/01/2024*

10080	Incision and drainage of pilonidal cyst
10081	

11770 11771 11772	Excision of pilonidal cyst or sinus
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Appropriate Pilonidal Cyst/ Sinus Diagnosis codes *Effective 03/01/2024*

L05.XX	Pilonidal cyst and sinus
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Applicable Decompression Procedure Codes *Effective 06/01/2024*

61783	Stereotactic computer-assisted (navigational) procedure; spinal
63001- 63053	Laminectomy

Applicable NPP modifiers *Effective 06/01/2024*

AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)

Applicable procedural modifiers *Effective 06/01/2024*

78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

**F. Frequently Asked Questions**

N/A

**G. Review/Revision Date**

Action	Date	Comments
Revision	04/30/2026	Policy template updated- No other content changes
Revision	04/01/2024	Guidance on modifiers 78, 79, NPP's and decompression procedures added (effective 06/01/2024)
Revision	1/30/2024	Guidance on pilonidal cyst and sinus procedures added (effective 03/01/2024)
Effective Date	11/01/2023	

## H. Resources

1. American Medical Association. *CPT Professional Edition 2025, AMA*; 2024.
2. American Medical Association. *ICD-10-CM 2026 the Complete Official Codebook, AMA*; 2025
3. Centers for Medicare & Medicaid Services. (2026). *Medicaid national correct coding initiative (NCCI) policy manual: Chapter 8—Surgery: Endocrine, nervous, eye and ocular adnexa, and auditory systems (CPT codes 60000–69999)*. <https://www.cms.gov/files/document/2026-medicaid-ncci-chapter-8-policy-manual.pdf>