AETNA BETTER HEALTH® of Illinois Policy

Policy Name:	Diagnosis Code Guideline Policy	Page:	1 of 4
Department:	Medical Payment Policy	Policy Number:	XXXX.XX
Subsection:		Effective Date:	11/1/2023
Applies to:	■ Medicaid Health Plans		

PURPOSE: This policy provides guidance for POS Codes.

STATEMENT OF OBJECTIVE: the policies below are based on CMS Guidelines

DEFINITIONS:

Aetna Better Health of Illinois	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Illinois Medicaid program.
The American Medical Association (AMA)	A professional group that publishes research to advance public health and advocates for the interests of registered physician-members.
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.
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 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.
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.
Medicare (CMS)	Medicare is a health insurance program for: people age 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).

Diagnosis Code Guideline Policy	Rules for correctly assigning and formatting ICD-10-CM coding, which are standard for classifying diseases in the U.S.
Diagnosis Validity Policy-Invalid Diagnosis Code	These are codes that have rules and guidelines for acceptable diagnosis codes submitted on claims. These diagnosis codes are "invalid", it means it does not meet a specific criteria for accurate and appropriate coding.

REIMBURSEMENT GUIDELINES:

Diagnosis Code Guideline Policy

- Factors Influencing Health Status and Contact with Health Services Diagnoses and NonRoutine Examinations According to the ICD Manual guidelines, diagnosis codes indicating "immunization not carried out and under immunization status" and "persons encountering health services for specific procedures and treatment, not carried out" indicate that the procedure was not carried out and therefore, is not eligible for reimbursement.
- Gestational Diabetes Coding According to our policy, which is based on the ICD-10-CM Official Guidelines for Coding and Reporting, diagnoses indicating long term use of insulin, hypoglycemic drugs or non-insulin antidiabetic drugs should not be assigned with codes for diabetes mellitus in pregnancy, childbirth and the puerperium.

Diagnosis Validity Policy-Invalid Diagnosis

- According to our policy, which is based on CMS Policy, CPT and HCPCS codes should be accompanied by valid ICD codes that are coded to the highest level of specificity.

LEGAL/CONTRACT REFERENCE:

- Federal and state laws, rules, and regulations concerning the practice of pharmacy, third party administration, Medicaid laws, rules, and regulations

- Applicable federal and state laws, regulations, and directives regarding the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])

FOCUS/DISPOSITION:

Responsibilities

The chief medical officer (CMO) and chief operating officer (COO) are responsible for review and implementation based upon state and federal regulation. Aetna Medicaid Administrators LLC applies editing rules as implemented by NCCI and AMA standards. Editing may also be developed based upon recommendations for specialty societies.

OPERATING PROTOCOL:

Systems

- Business application systems

Measurement

- Edit Accuracy
- Edit Application
- Overturn of Adjustment Rates

Reporting

- Aetna Medicaid - Cotiviti Healthcare Monthly Performance Summary to plan leadership
- Claim Check Monthly Summary to health plans

INTER-/INTRADEPENDENCIES:

Internal

- Medical Payment Policy
- Payment Integrity Center of Excellence, Service Operations (PIAB)
- Chief Medical Officer
- Chief Operating Officer
- Claims
- Finance

- Medical Management
- Special Investigations Unit

External

- Clinical Editing Vendors
- Practitioners
- Providers
- Regulatory Departments
- Vendors
- Aetna Better Health

Kimberly Foltz
Interim Chief Executive Officer

Glen Davis, MD
Chief Medical Officer

Review/Revision History	
Revised	08/25/2025