DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3)

Section Numbers:	Proposed Action:
140.11	Amendment
140.16	Amendment
140.71	Amendment
140.402	Amendment
140.459	Amendment
140.461	Amendment
140.462	Amendment
140.464	Amendment
140.930	Amendment
140.Table J	New
140.Table M	Repeal

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11].

5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? Yes

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other rulemakings pending on this Part? Yes

Sections	Proposed Action	Illinois Register Citation
140.462	Amendment	37 Ill. Reg. 12637; August 16, 2013
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013

140.2	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.3	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.6	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.441	Amendment	38 Ill. Reg. 2529; January 17, 2014

11) Statement of Statewide Policy Objectives: These proposed amendments neither create nor expand any State mandate affecting units of local government.

12) Information and questions regarding this amendment shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233

HFS.Rules@illinois.gov.

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this Rulemaking was Summarized: January 2014

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

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Section
140.1 Incorporation By Reference
140.2 Medical Assistance Programs
EMERGENCY
140.3 Covered Services Under Medical Assistance Programs
EMERGENCY
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under General Assistance
140.6 Medical Services Not Covered
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140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Persons Confined or Detained by the Criminal Justice System

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section
140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Suspension and Denial of Payment, Recovery of Money and Penalties
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140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance

Program
140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension, Exclusion or Barring
140.20 Submittal of Claims
140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
140.22 Magnetic Tape Billings (Repealed)
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140.33 Publication of List of Sanctioned Entities
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140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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140.97 Special Requirements (Recodified)
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140.102 Heart Transplants (Recodified)
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140.116 Payment for Inpatient Services for GA (Recodified)
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140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
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140.364 Prepayment Review (Recodified)
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140.366 Restructuring Adjustment (Recodified)
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140.370 Rate Calculation (Recodified)
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140.420 Dental Services
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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services (Repealed)

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended

at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended

at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1,

1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December

19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25

Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a

maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; peremptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011; amended at 35 Ill. Reg. 7962, effective May 1, 2011;

amended at 35 Ill. Reg. 10000, effective June 15, 2011; amended at 35 Ill. Reg. 12909, effective July 25, 2011; amended at 36 Ill. Reg. 2271, effective February 1, 2012; amended at 36 Ill. Reg. 7010, effective April 27, 2012; amended at 36 Ill. Reg. 7545, effective May 7, 2012; amended at 36 Ill. Reg. 9113, effective June 11, 2012; emergency amendment at 36 Ill. Reg. 11329, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 140.442(e)(4) suspended at 36 Ill. Reg. 13736, effective August 15, 2012; suspension withdrawn from Section 140.442(e)(4) at 36 Ill. Reg. 14529, September 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.442(e)(4) at 36 Ill. Reg. 14820, effective September 21, 2012 through June 30, 2013; emergency amendment to Section 140.491 suspended at 36 Ill. Reg. 13738, effective August 15, 2012; suspension withdrawn by the Joint Committee on Administrative Rules from Section 140.491 at 37 Ill. Reg. 890, January 8, 2013; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.491 at 37 Ill. Reg. 1330, effective January 15, 2013 through June 30, 2013; amended at 36 Ill. Reg. 15361, effective October 15, 2012; emergency amendment at 37 Ill. Reg. 253, effective January 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 846, effective January 9, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 1774, effective January 28, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 2348, effective February 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 3831, effective March 13, 2013; emergency amendment at 37 Ill. Reg. 5058, effective April 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 5170, effective April 8, 2013 through June 30, 2013; amended at 37 Ill. Reg. 6196, effective April 29, 2013; amended at 37 Ill. Reg. 7985, effective May 29, 2013; amended at 37 Ill. Reg. 10282, effective June 27, 2013; amended at 37 Ill. Reg. 12855, effective July 24, 2013; emergency amendment at 37 Ill. Reg. 14196, effective August 20, 2013, for a maximum of 150 days; amended at 37 Ill. Reg. 17584, effective October 23, 2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg.______, effective January 29, 2014; amended at 38 Ill. Reg.______, effective________________.

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.11 Enrollment Conditions for Medical Providers

a) In order to enroll for participation, providers shall:

1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors.;

2) Be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX participation.~~;~~

3) Be certified for Title XIX when federal or State rules and regulations so require.~~;~~

4) Provide enrollment information to the Department in the prescribed format, and notify the Department, in writing, immediately whenever there is a change in any such information which the provider has previously submitted.~~;~~

5) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to public aid recipients.~~; and~~

6) Have a written provider agreement on file with the Department.

b) Approval of a corporate entity such as a pharmacy, laboratory, durable medical equipment and supplies provider, medical transportation provider, nursing home or renal satellite facility, as a participant in the Medical Assistance Program, applies only to the entity's existing ownership, corporate structure and location; therefore, participation approval is not transferable.

c) Except for children's hospitals described at 89 Ill. Adm. Code 148.25(d)(3)(B)~~149.50(c)(3)~~, hospitals providing inpatient care that are certified under a single Centers for Medicare and Medicaid Services certification ~~Medicare~~ number shall be enrolled as a single ~~an individual~~ entity in the Medical Assistance Program. A children's hospital must be separately enrolled from the general care hospital with which it is affiliated.

d) Upon notification from the Illinois Department of Public Health of a change of ownership, the Department shall notify the prospective buyer of its obligation under Section 140.12(l) to assume liability for repayment to the Department for overpayments made to the current owner or operator. Such notification shall inform the prospective buyer of all outstanding known liabilities due to the Department by the facility and of any known pending Department actions against the facility that may result in further liability. For long term care providers, when

there is a change of ownership of a facility or a facility is leased to a new operator, the provider agreement shall be automatically assigned to the new owner or lessee. Such assigned agreement shall be subject to all conditions under which it was originally issued, including, but not limited to, any existing plans of correction, all requirements of participation as set forth in Section 140.12 or additional requirements imposed by the Department.

e) For purposes of administrative efficiency, the Department may periodically require classes of providers to re-enroll in the Medical Assistance Program. Under such re-enrollments, the Department shall request classes of providers to submit updated enrollment information. Failure of a provider to submit such information within the requested time frames will result in the disenrollment~~dis-enrollment~~ of the provider from the Program. Such disenrollment~~dis-enrollment~~ shall have no effect on the future eligibility of the provider to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program. A disenrolled~~dis-enrolled~~ provider may reapply to the Program and all such re-applications must meet the requirements for enrollment.

f) For purposes of this Section, a vendor whose investor ownership has changed by 50 percent or more from the date the vendor was initially approved for enrollment in the Medical Assistance Program shall be required to submit a new application for enrollment in the Medical Assistance Program. All such applications must meet the requirements for enrollment.

g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a vendor is subject to a provisional period and shall be conditional for one year unless limited by the Department. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the Medical Assistance Program without cause. Upon termination of a vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:

1) Individuals~~individuals~~ with management responsibility;

2) All~~all~~ owners or partners in a partnership;

3) All~~all~~ officers of a corporation or individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporation; or

4) Anan owner of a sole proprietorship.

h) Unless otherwise specified, the termination of eligibility or vendor disenrollment, as described in subsection (g) of this Section, and resulting barrments are not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

(Source: Amended at 38 Ill. Reg. __________, effective _________________)

Section 140.16 Termination, Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program

a) TheEffective July 1, 2012, the Department may terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, terminate or not renew a vendor's provider agreement, or exclude a person or entity from participation in the Medical Assistance Program, when it determines that, at any time:

1) The vendor is not complying with the Department's policy or rules, or with the terms and conditions prescribed by the Department in any vendor agreement developed as a result of negotiations with the vendor category, or with the covenants contained in certifications bearing the vendor's signature on claims submitted to the Department by the vendor, or with restrictions on participation imposed pursuant to Section 140.32(f);

2) The vendor, person or entity is not properly licensed, certified, authorized or otherwise qualified, or the vendor person's or entity's professional license, certificate or other authorization has not been renewed or has been restricted, revoked, suspended or otherwise terminated as determined by the appropriate licensing, certifying or authorizing agency. The termination, suspension or exclusion shall be immediately effective;

3) The vendor violates records requirements as set forth in statute or Department rules, provider handbooks or policies.

A) The vendor has failed to keep or timely make available for inspection, audit or copying (including photocopying), after receiving a written request from the Department:

i) records required to be maintained by the Department or necessary to fully and completely disclose the extent of the services or supplies provided; or

ii) full and complete records required to be maintained by the Department regarding payments claimed for providing services.

B) This subsection (a)(3) does not require vendors to make available medical records of patients for whom services are not reimbursed under the Illinois Public Aid Code;

4) The vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services, or has failed to furnish all information required by the Department in connection with the rendering of services or supplies to recipients of public assistance by the vendor or his or her agent, employer or employee;

5) The vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Medical Assistance Program. For purposes of this subsection (a)(5), statements or representations made "knowingly" shall include statements or representations made with actual knowledge that they were false as well as those statements made when the individual making the statement had knowledge of such facts or information as would cause one to be aware that the statements or representations were false when made;

6) The vendor has submitted claims for services or supplies that were not rendered or delivered by that vendor;

7) The vendor has furnished goods or services to a recipient that, when based upon competent medical judgment and evaluation, are determined to be:

A) in excess of needs;

B) harmful (for the purpose of this subsection (a)(7)(B), "harmful" goods or services cause actual harm as defined in Section 140.13 or place an individual at risk of harm, or of adverse side effects, that outweigh the medical benefits sought); or

C) of grossly inferior quality;

8) The vendor knew or should have known that a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an investor in the vendor, a technical or other advisor of the vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor was previously terminated, suspended, excluded or barred from participation in the Medical Assistance Program, or in another state or federal medical assistance or health care program;

9) The vendor has a delinquent debt owed to the Department;

10) The vendor engaged in practices prohibited by federal or State law or regulation.

A) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor, either:

i) has engaged in practices prohibited by applicable federal or State law or regulation; or

ii) was a person with management responsibility for a vendor at the time that the vendor engaged in practices prohibited by applicable federal or State law or regulation; or

iii) was an officer, or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a vendor at the time the vendor engaged in practices prohibited by applicable federal or State law or regulation; or

iv) was an owner of a sole proprietorship or partner of a partnership that was a vendor at the time the vendor

engaged in practices prohibited by applicable federal or State law or regulation;

B) For purposes of this subsection (a)(10), "applicable federal or State law or regulation" includes, but is not limited to, licensing or certification standards contained in State or federal law or regulations related to the Medical Assistance Program, any other licensing standards as they relate to the vendor's practice or business or any federal or State laws or regulations related to the Medical Assistance Program;

C) For purposes of this subsection (a)(10), conviction or a plea of guilty to activities violative of applicable federal or State law or regulation shall be conclusive proof that those activities were engaged in;

11) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor has been convicted in this or any other State, or in any Federal Court, of any offense not related to the Medical Assistance Program, if the offense constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;

12) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or partner in a partnership that is a vendor has been convicted in this or any other state, or in any Federal Court, of:

A) murder;

B) a Class X felony under the Illinois Criminal Code of 1961;

C) sexual misconduct that may subject recipients to an undue risk of harm;

D) a criminal offense that may subject recipients to an undue risk of harm;

E) a crime of fraud or dishonesty;

F) a crime involving a controlled substance;

G) a misdemeanor relating to fraud, theft, embezzlement or breach of fiduciary responsibility; or

H) other financial misconduct related to a health care program.

13) The direct or indirect ownership of the terminated, suspended or excluded vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage.

b) The Department may suspend a vendor's eligibility to participate in the Medical Assistance Program if the vendor is not in compliance with State income tax requirements, child support payments in accordance with Article X of the Illinois Public Aid Code, or educational loans guaranteed by the Illinois Student Assistance Commission. The vendor may prevent suspension of eligibility by payment of past-due amounts in full or by entering into payment arrangements acceptable to the appropriate State agency.

c) The ~~Effective July 1, 2012, the~~ Department may terminate, suspend or exclude vendors who pose a risk of fraud, waste, abuse or harm, as defined in Section 140.13, from participation in the Medical Assistance Program.

(Source: Amended at 38 Ill. Reg. __________, effective________________________)

Section 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments

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a) C-13 Invoice Voucher Advance Payments

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

   A) are enrolled with the Department ~~of Public Aid~~;

   B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

      i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired; or

      ii) cash flow problems encountered by a provider or group of providers which are unrelated to agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;

   C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

      i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

      ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vi) for government-owned facilities, this subsection (a)(1)(C) may be waived if the cash flow criterion~~criteria~~ under subsection (a)(1)(B)(ii) is met; and

vii) for providers who have filed for Chapter 11 bankruptcy, this subsection (a)(1)(C) may be waived if the cash flow criterion~~criteria~~ under subsection (a)(1)(B)(ii) are met;

D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:

i) specific reason(s) for advanced payments;

ii) specific amount agreed to be advanced;

iii) specific date to begin recoupment; and

iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System (MMIS) voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).

2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.

3) Approval Process

A) In order to obtain C-13 advance payments, providers must submit their request in writing (telefacsimile and email telefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the circumstances creating the need for the advance payments;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the amount of the advance required.

B) An agreement will be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to release of the warrant.

C) C-13 advance payments shall be authorized for the provider following approval by the Medicaid Administrator of the Division of Medical Programs or designee. Once all requirements of this subsection (a)(3) are met, the Administrator will authorize payment within seven days.

4) Recoupment

A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.

B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six months from the month in which payment is authorized. For

those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.

C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Department pursuing other collection methods.

5) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section ~~rule~~ will remain in effect, notwithstanding the provisions of this Section .

b) Expedited Claims Payments

1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital qualified and participating under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department ~~of Public Aid~~;

B) have experienced an emergency which necessitates expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances

which may create such emergencies include, but are not limited to, the following:

i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to the clients is severely impaired;

ii) cash flow problems encountered by a provider or group of providers which are unrelated to Department technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing system problems) or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider adversely impacting on the ability to serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospitals must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

~~iv) for hospitals that qualify as disproportionate share hospitals as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122 and receive Rehabilitation Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(b)) or Direct Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(c)(1)), a request must be made in writing that demonstrates proof of cash flow problems;~~

ivv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

vvi) for sole source pharmacies in a community that are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vivii) for government-owned facilities, this subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met; and

viiviii) for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (b)(1)(B)(ii) are met.

2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.

3) Approval Process

A) In order to qualify for expedited payments, providers must submit their request in writing (telefacsimile and emailtelefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the need for the expedited payments; and

ii) supportive documentation to substantiate the emergency nature of the request.

B) Expedited payments shall be authorized for the provider following approval by the Medicaid Administrator of the Division of Medical Programs or designee.

C) The Department will periodically review the need for any continued expedited payments.

4) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section rule will remain in effect, notwithstanding the provisions of this Section .

(Source: Amended at 38 Ill. Reg. _______, effective _________________)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.402 Copayments for Non-institutional Medical Services

The following implements cost sharing in compliance with 42 USC 1396o (section 1916 of the Social Security Act):

a) Each Effective July 1, 2012, each recipient, with the exception of those classes of recipients identified in subsection (d) of this Section, shall be required to pay a copayment of $2.00 for generic legend drugs and over-the-counter drugs billed to the Department, and for other services, with the exception of those services identified in subsection (e), the nominal copayment amount as defined at 42 CFR 447.54. For dates of service beginning July 1, 2012 through March 31, 2013 the nominal copayment amount is $3.65. Beginning with dates of service on April 1, 2013, the nominal copayment amount is $3.90. Specific copayment amounts are described and updated on the Department's Web site for the following non-institutional medical services:

1) Office visits to enrolled practitioners for services reimbursed under the Illinois Public Aid Code.

2) Each brand name legend drug billed to the Department.

3) Each encounter billed to the Department by an Encounter Rate Clinic (ERC), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), but excluding behavioral services provided by these facilities. For dates of service beginning July 1, 2013, copayments for behavioral health services provided by these facilities are no longer excluded and shall be required to be paid by recipients with the exception of those classes of recipients identified in subsection (d).

b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the respective amount of the required copayment.

c) No provider of services listed in subsection (a) may deny service to an individual who is eligible for service on account of the individual's inability to pay the cost of a copayment.

d) The following individuals receiving medical assistance are exempt from the copayment requirement set forth in subsection (a):

1) Pregnant women, including a postpartum period of 60 days.

2) Children under 19 years of age.

3) All non-institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections.

4) Hospice patients.

5) Individuals residing in hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled who, as a condition of receiving services, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their care. For the purpose of this subsection (d)(5), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).

6) Residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their residential care program. For the purpose of this subsection (d)(6), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).

7) Individuals enrolled in the "Health Benefits for Person with Breast or Cervical Cancer" program under 89 Ill. Adm. Code 120.500.

8) American Indians or Alaskan Natives.

e) The following medical services are exempt from any copayments:

1) Renal dialysis treatment.

2) Radiation therapy.

3) Cancer chemotherapy.

4) Insulin.

5) Services for which Medicare is the primary payer.

6) Emergency services as defined at 42 USC 1396u-2(b)(2) (section 1932(b)(2) of the Social Security Act) and 42 CFR 438.114(a).

7) Any pharmacy compounded drugs.

8) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.

9) Family planning services and supplies described in 42 USC 1396d(a)(4)(C) (section 1905(a)(4)(C) of the Social Security Act), including contraceptives and other pharmaceuticals for which the State claims or could claim federal financial participation ~~match~~ at the enhanced rate under 42 USC 1396b(a)(5) (section 1903(a)(5) of the Social Security Act) for family planning services and supplies.

10) Other therapeutic drug classes as specified by the Department.

11) Preventive services as described in section 4106(b) of the Affordable Care Act.

(Source: Amended at 38 Ill. Reg. __________, effective _________________)

Section 140.459 Payment for Therapy Services

a) Therapy services shall be paid at an all-inclusive ~~per half-hour~~ rate which shall be the lower of:

1a) The providers usual and customary charge for services.; of

2b) The maximum reimbursement rate established by the Department.

b) Maximum reimbursement rates. The maximum reimbursement rate:

1) For outpatient physical rehabilitation services provided by a hospital – paid per visit and limited to one visit per day:

A) That is a children's hospital, as defined in paragraph 148.25(d)(3)(A), enrolled with the Department to provide outpatient physical rehabilitation shall be $130.00.

B) Enrolled with the Department to provide outpatient physical rehabilitation shall be $130.00.

C) Not enrolled with the Department to provide outpatient physical rehabilitation shall be $115.00.

2) For all other therapy services – paid per quarter hour, shall be as published in fee schedules on the Department's website.

(Source: Amended at 38 Ill. Reg. ___________, effective __________________)

Section 140.461 Clinic Participation, Data and Certification Requirements

a) Hospital-based organized clinics must:

1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care.;

2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers.;

3) Meet one of the following requirements:

A) Bebe adjacent to or on the premises of a the hospital and be

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i) licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or

ii) that meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.

B) Havehave provider-based status under Medicare pursuant to 42 CFR 413.65.; or

C) Bebe clinically integrated as evidenced by all of the following:

i) Professional professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital.; and

ii) Fullyfully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic.; and

iii) Heldheld out to the public and other payers as part of the main hospital.; and

iv) Operatedoperated under the ownership and control of the main hospital, as evidenced by the following: the business

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enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic.~~; and~~

v) Located~~located~~ within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.

4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).

b) Encounter rate clinics must, (i) have participated ~~participate~~ in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998, or (ii) be a clinic operated by an Illinois ~~a~~ county with a population of over three million. Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Maternal and Child Health Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2).

c) Rural health clinics must be certified by the Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ as meeting the requirements for Medicare participation.

d) Federally Qualified Health Centers (FQHC):

1) Must meet one of the following criteria~~be Health Centers which~~:

A) Receive ~~receive~~ a grant under Section 329, 330 or 340 of the Public Health Service Act (42 USC 329, 330, 340).~~; or~~

B) Based~~based~~ on the recommendation of the Health Resources and Services Administration within the U.S. Department of Health and Human Services~~Public Health Service~~, are determined to meet the requirements for receiving such a grant.

2) ~~Section 4602 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which amended~~ Section 1902(a)(55) of the Social Security Act (42 USC ~~Section~~ 1396a(a)(55)), requires states to receive and initially process Medicaid applications from low-income pregnant women and children under 19 years of age at locations other than the local Department of Human Services (DHS) office. Such a site is referred to as an outstation.

A) Outstations will be located at those FQHCs which the Department determines serve heavy Medicaid populated areas. For areas in which the Department determines that maintaining outstation workers is not economical, the DHS <u>Family Community Resource Center (FCRC)</u> ~~local office~~ will continue to be the application location.

B) The FQHCs, which will provide outstation eligibility staff to accept and assist in the initial processing of the Medicaid application for pregnant women and children, will forward the completed application to the appropriate DHS <u>FCRC</u> local office. Initial processing means accepting and completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews. Neither the FQHCs nor the outstation workers will evaluate the information contained on the application, nor make any determination of eligibility or ineligibility. The DHS <u>FCRC</u> ~~local office~~ is responsible for these functions.

C) Costs allowable under the federal outstation mandate for completing the Medicaid application will be itemized in Section B of Schedule I of the FQHC Medicaid cost report and will be provided annually in the FQHC cost reporting process. These allowable costs will be collected, computed and calculated, and will result in the establishment of an outstation administrative rate and a Medicaid rate. The allowable costs are:

i) Salary of outstation worker<u>.</u>~~;~~

ii) Fringe benefits<u>.</u>~~;~~

iii) Training.;

iv) Travel. ; and

v) Supplies.

D) FQHC outstation workers must receive certification through Maternal and Child Health (MCH) process training by the Department before they begin to perform eligibility processing functions. Failure to become certified results in any MCH application completed by an ineligible worker being non-allowed on the cost report.

E) FQHCs must have adequate staff trained with proper backup to accommodate unforeseen problems. FQHCs must be able to meet the demand of this initiative, either using staff at one location or rotating staff as dictated by workload or staffing availability. The FQHC must have staff available at each outstation location during regular office operating hours.

F) Outstation intake staff may perform other FQHC intake processing functions, but the time spent on outstation activities must be documented and must be identifiable for cost reporting and auditing purposes.

G) The FQHC must display a notice in a prominent place at the outstation location advising potential applicants of the times that outstation intake workers will be available. The notice must include a telephone number that applicants may call for assistance.

H) The FQHC must comply with federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.

~~f) Maternal and Child Health Clinics~~

1) Types of Clinics
The following clinics shall qualify as Maternal and Child Health Clinics:

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A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC) that are hospital-based organized outpatient clinics, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide ambulatory primary care to Medicaid children from birth through 20 years of age, and pregnant women in a non-emergency room setting. At least 50 percent of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHAPCC must be for primary care.

B) Certified Hospital Organized Satellite Clinics (CHOSC) that are clinics meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that are owned, operated, and/or managed by a hospital but do not qualify as hospital-based organized clinics, as described in subsection (a), because they are not located adjacent to or on the premises of the hospital or are not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency setting to Medicaid children from birth through 20 years of age, and to pregnant women. At least 50 percent of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized expertise necessary for the provision of secondary and tertiary care. CHOSCs shall meet the requirements in subsections (a)(1) and (a)(2).

C) Certified Obstetrical Ambulatory Care Centers (COBACC) that are hospital-based organized clinic entities, as described in subsection

~~(a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide primary care and specialty services to Medicaid-eligible pregnant women, especially those determined to be non-compliant or at high risk, in an outpatient setting.~~

~~D) Certified Pediatric Ambulatory Care Centers (CPACC) that are hospital-based organized clinic entities, as described in subsection (a), owned and operated by a hospital as described in 89 Ill. Adm. Code 149.50(c)(3), and meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide pediatric primary care and specialty services as described in Section 140.462(e)(3)(C) to Medicaid enrolled children with specialty needs, from birth through 20 years of age in an outpatient setting. Hospitals with CPACCs must also provide primary care for at least 1,500 children, either through its CPACC or through a CHAPCC, CHOSC or encounter rate clinic operated by the same hospital. Hospitals unable to meet this volume requirement must agree to serve as a specialty referral site for another hospital operating a CPACC through a written agreement submitted to the Department.~~

~~2) General Participation Requirements~~
~~In addition to the Maternal and Child Health participation requirements described in Section 140.924(a)(1), the Maternal and Child Health clinics identified in subsection (f)(1) must:~~

~~A) Be operated by a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 pregnant women or children; or be a primary care teaching site of an organized academic department of:~~

~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), a pediatric or family practice residency program~~

~~accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.~~

~~ii) In the case of clinics described in subsection (f)(1)(C), an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~

~~iii) In the case of clinics described in subsection (f)(1)(D), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~

~~B) Under the direction of a board certified/eligible physician who has hospital admitting and/or delivery privileges and provides direct supervision to residents practicing in the certified ambulatory site, provide:~~

~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), primary care.~~

~~ii) In the case of clinics described in subsection (f)(1)(C), obstetric and specialty services.~~

~~iii) In the case of clinics described in subsection (f)(1)(D), primary care and specialty services.~~

~~C) Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO);~~

~~D) Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department; and~~

~~E) Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality.~~

~~3) Special Participation Requirements~~
~~In addition to the Maternal and Child Health provider participation requirements described in Section 140.924(a)(1), and the general participation requirements described in subsection (f)(2), special participation requirements shall apply as follows:~~

~~A) Clinics described in subsections (f)(1)(A) and (f)(1)(B) must:~~

~~i) Serve a total population that includes at least 20 percent Medicaid and medically indigent clients;~~

~~ii) Perform a risk assessment on pregnant women assigned to them in order to determine if the woman is at high risk; and~~

~~iii) Provide or arrange for specialty services when needed by pregnant women or children.~~

~~B) Clinics described in subsection (f)(1)(C) must:~~

~~i) Be a distinct department of a hospital that also operates as a Level II, Level II with Extended Neonatal Capabilities or Level III perinatal center;~~

~~ii) Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to women who currently are Medicaid clients, or Medicaid-eligible women who receive services at the COBACC; in this capacity, COBACCs, as perinatal centers, shall serve pregnant women determined to be at high risk of abnormal delivery;~~

~~iii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;~~

~~iv) Have an established program of services for the treatment of substance-abusing pregnant women;~~

~~v) Integrate an accredited obstetrical residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and~~

~~vi) Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.~~

~~C) Clinics described in subsection (f)(1)(D) must~~:

~~i) Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition as described in Section 140.462(e)(3)(C);~~

~~ii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of pediatric emergencies;~~

~~iii) Provide access to necessary pediatric primary and specialty services within 24 hours after referral;~~

~~iv) Be a distinct department of a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120(a)(5);~~

~~v) Integrate an accredited pediatric or family practice residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty needs; and~~

~~vi) Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.~~

~~4) Data Requirements~~
~~The Maternal and Child Health clinics described in subsection (f)(1) shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.~~

~~5) Certification Requirements~~
~~Certification of qualifying status of a Maternal and Child Health clinic identified in subsection (f)(1) shall occur annually during the first two years of participation and every other year thereafter. In addition:~~

~~A) The certification process shall consist of a review of the completed application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on-site by Department staff within 60 days after application approval. Final notification of certification status shall be rendered within 30 days after the site review, pending provider submittal of a written plan of correction for any deficiencies discovered during the entire application process.~~

~~B) Entities interested in becoming a Maternal and Child Health clinic must direct a written request for an application packet to the following address:~~

~~Maternal and Child Health Clinic Certification~~
~~Bureau of Comprehensive Health Services~~
~~Illinois Department of Public Aid~~
~~201 South Grand Avenue East, Concourse~~
~~Springfield, Illinois 62763-0001~~

~~C) Certification status shall be suspended for Maternal and Child Health clinics identified in subsection (f)(1) that do not submit data to the Department, as required under subsection (f)(4), within 180 days after the Department's request for the submittal of such data.~~

fg) School Based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 Ill. Adm. Code 2200). Examples of certification requirements include:

1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.

2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.

3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners ~~(see Section 140.400)~~, must be under the direction of a physician.

4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.

5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will provide ongoing monitoring to assure that appropriate standards are followed.

6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure

that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.

7) The center must establish procedures for the availability of primary care providers and for 24-hour per day, 12-month per year access to routine, urgent and emergency care, telephone appointments and advice. The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24-hour back-up services when the center is not open.

8) Services may be provided to eligible students who have obtained written parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.

9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.

10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE) enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.

A) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider or MCE to obtain a referral for a specialist.

B) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.

11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring

continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.

12) Data Requirements
The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

gh) Hospital Outpatient Departments
Hospital outpatient departments may include facilities that meet the requirements of subsection (a)(3) of this Section.

h) County-operated outpatient facilities. A county-operated outpatient facility is a non-hospital-based clinic operated by and located in an Illinois county with a population exceeding three million.

1) Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility, that is within or adjacent to a large public hospital as defined in 89 Ill. Adm. Code 148.25(a)(1).

2) County ambulatory health centers. A county ambulatory health center is a County-operated outpatient facility that is not a critical clinic provider.

3) County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. ______, effective ____________________)

Section 140.462 Covered Services in Clinics

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-Based Organized Clinics

1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e), as appropriate.

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1~~2~~) ~~With respect to all other hospital-based organized clinics,~~ Covered~~covered~~ services ~~are those~~ described in 89 Ill. Adm. Code 148.

2~~3~~) Group psychotherapy services meeting ~~must meet~~ the guidelines set forth in Section 140.413(a)(4)(C).

b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924~~(a)(2)(B)~~, covered services are those described in Section 140.922.

2) With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.

3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

c) Rural Health Clinics
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) speech and hearing services;

I) x-ray services;

J) health education;

K) nutrition services;

L) optometric services.

4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services with the exception of services identified in subsections (c)(7) and (c)(8).

7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an RHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) The RHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the RHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

8) Effective July 1, 2013, an RHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

d) Federally Qualified Health Centers
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which separate encounters may be billed include dentists and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) optometric services;

I) speech and hearing services;

J) x-ray services;

K) health education;

L) nutrition services.

4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided with the exception of services identified in subsections (d)(7) and (d)(8).

7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an FQHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) The FQHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

8) Effective July 1, 2013, an FQHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

~~e) Maternal and Child Health Clinics~~

~~Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:~~

~~1) In the case of clinics described in Section 140.461(f)(1)(A) and (f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:~~

~~A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~

~~B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;~~

~~C) Regular immunizations for the prevention of childhood diseases;~~

~~D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;~~

~~E) Routine prenatal care, including risk assessment, for pregnant women; and~~

~~F) Specialty care as medically needed.~~

~~2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:~~

~~A) Prenatal care, including risk assessment (one risk assessment per pregnancy);~~

~~B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and~~

~~C) Services to pregnant women with diagnosed substance abuse or addiction problems.~~

~~3) In the case of clinics described in Section 140.461(f)(1)(D):~~

~~A) Comprehensive medical and referral services.~~

~~B) Primary care services, which must include, but are not necessarily limited to:~~

~~i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~

~~ii) regular immunizations for the prevention of childhood diseases; and~~

~~iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening~~.

~~C) Pediatric specialty services, which must include, at a minimum, necessary treatment for:~~

~~i) asthma,~~

~~ii) congenital heart disease,~~

~~iii) diabetes, and~~

~~iv) sickle cell anemia.~~

~~D) Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.~~

e~~f~~) School Based/Linked Health Clinics (Centers)
Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(f)~~(g)~~:

1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical

Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 38 Ill. Reg. __________, effective ________________)

Section 140.464 Hospital-Based and Encounter Rate Clinic Payments

a) Hospital-Based Organized Clinics as described in Section 140.461(a) shall be paid in accordance with 89 Ill. Adm. Code 148.140

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~~1) With respect to those hospital-based organized clinics, as described at Section 140.461(a), that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), payment shall be in accordance with Section 140.930.~~

~~2) With respect to all other hospital-based organized clinics, payment shall be in accordance with 89 Ill. Adm. Code 148.140.~~

b) Encounter Rate Clinics

1) For encounter rate clinics, as described at Section 140.461(b), providing comprehensive health care for infants and women, including but not limited to prenatal and postnatal care, payment shall be made at the lesser of:

A) $90 per encounter; or

B) The clinic's charge to the general public.

2) For encounter rate clinics, as described at Section 140.461(b), providing dental services, payment shall be made at the lesser of:

A) $85 per encounter; or

B) The clinic's historical annual cost per encounter as calculated for a Federally Qualified Health Center (FQHC) in accordance with Section 140.463(b)(3)(B).

3) For all other encounter rate clinics, payment shall be made at the lesser of:

A) The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

B) $50 per encounter; or

C) The clinic's charge to the general public.

c) County-operated outpatient facilities.

1) For critical clinic providers, as described in Section 140.461(h)(1), reimbursement for all services, including pharmacy-only-encounters, provided shall be on an all-inclusive per day encounter rate that shall equal reported direct costs of Critic al Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.

2) For county ambulatory health centers, the final rate is determined as follows:

A) Base rate. The base rate shall be the rate calculated as follows:

i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

ii) The resulting quotient, as calculated in subsection (i) of this subsection (c)(2)(A), shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

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iii) The resulting product, as calculated in subsection (ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (i) of this subsection (c)(2)(A), to determine the per encounter base rate.

iv) The resulting sum, as calculated in subsection (iii) of this Section, shall be the base rate.

B) Supplemental rate

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i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

iii) The quotient derived in subsection (i) of this subsection (c)(2)(B), shall be added to the product derived in subsection (ii) of this Section, to determine the per encounter supplemental rate.

iv) The resulting sum, as described in subsection (iii) of this subsection (c)(2)(B), shall be the supplemental rate.

C) Final rate. The final rate shall be the sum of the base rate and the supplemental rate.

(Source: Amended at 38 Ill. Reg. __________, effective _________________)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section 140.930 Reimbursement

a) Reimbursement Rates for Maternal and Child Health Providers

~~1) Participating providers described in Section 140.924(a)(1) will receive enhanced rates for certain medical services specified in Table M of this~~

Part. The enhanced rates are effective for services provided on or after April 1, 1993.

12) Participating FQHC's, as described in Section 140.461(d), that meet the criteria specified in 140.924(a)(2)(A), shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.

23) Participating encounter rate clinics shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.

4) Participating Maternal and Child Health clinics, as described in Sections 140.924 and 140.461(f), will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.

35) Participating providers described in Section 140.924(a)(1) shall be eligible to receive a Well Child Visit Incentive Payment.

A) The provider will receive a one-time annual payment of $30 for each qualifying child.

B) A qualifying child is a child who had its first, second, third, fourth or fifth birthday during the calendar year and for whom the provider personally, or through an affiliated provider, rendered all recommended well child visits, as described in Section 140.488.

C) Recommended services must be rendered during the 13-month period ending one month after the child's birthday. For children turning one year old, the period begins ten days after birth and ends one month after the child's birthday. Rendering of services will be based on Department claims data.

D) The first incentive payments shall be made by June 30, 2007 for children who met the definition of a qualifying child during calendar year 2005. PaymentsSubsequent payments will be made at least annually.

E) For the purpose of payments under this Section, "affiliated provider" shall mean providers designated pursuant to Section 140.994.~~:~~

~~i) For qualifying children during calendar year 2005 through 2007, a provider with the same payee in accordance with Section 140.24(d).~~

~~ii) For qualifying children during calendar year 2008 and later, providers designated pursuant to Section 140.994.~~

b) Patient Management Fee
Providers who have accepted primary care responsibilities for foster children residing in Cook County who are under the guardianship of the Department of Children and Family Services will receive a monthly patient management fee for each client enrolled with them.

c) Case Management Services
Providers of case management services will receive monthly payments. The payments will be prorated based upon an annual amount per case.

(Source: Amended at 38 Ill. Reg. __________, effective ________________)

SUBPART L: UNAUTHORIZED USE OF MEDICAL ASSISTANCE

Section 140.TABLE J Rate Regions~~HSA Grouping (Repealed)~~

These geographic regions, comprised of counties, are used in various rate methodologies and are defined as follows:

Region 1–Northwestern.

Illinois Counties:

Boone	Bureau	Carroll	DeKalb	Fulton
Henderson	Henry	JoDaviess	Knox	LaSalle
Lee	Marshall	Mercer	Ogle	Peoria
Putnam	Rock Island	Stark	Stephenson	Tazewell
Warren	Whiteside	Winnebago	Woodford	

Out of State Counties:

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Des Moines, IA	Clinton, IA	Dubuque, IA	Johnson, IA	Scott, IA
Dane, WI	Green, WI	Rock, WI	Grant, WI	LaFayette, WI
Jackson, IA	Muscatine, IA	Louisa, IA		

Region 2–Central.

Illinois Counties:

Adams	Brown	Calhoun	Cass	Champaign
Christian	Clark	Coles	Cumberland	DeWitt
Douglas	Edgar	Ford	Greene	Hancock
Iroquois	Jersey	Livingston	Logan	Macon
Macoupin	Mason	McDonough	McLean	Menard
Montgomery	Morgan	Moultrie	Piatt	Pike
Sangamon	Schuyler	Scott	Shelby	Vermilion

Out of State Counties:

Marion, IN	Vigo, IN	Marion, MO	Clark, MO	Lewis, MO
Ralls, MO	Pike, MO	Lincoln, MO	Newton, IN	Benton, IN
Warren, IN	Vermillion, IN			

Region 3–Southern.

Illinois Counties:

Alexander	Bond	Clay	Clinton	Crawford
Edwards	Effingham	Fayette	Franklin	Gallatin
Hamilton	Hardin	Jackson	Jasper	Jefferson
Johnson	Lawrence	Madison	Marion	Massac
Monroe	Perry	Pope	Pulaski	Randolph
Richland	Saint Clair	Saline	Union	Wabash
Washington	Wayne	White	Williamson	

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Out of State Counties:

Vanderburgh, IN	McCracken, KY	Cape Girardeau, MO	
St. Louis, MO	City of St. Louis, MO	St. Charles, MO	Jefferson, MO
Gibson, IN	Ste. Genevieve, MO	Perry, MO	Scott, MO
Mississippi, MO	Posey, KY	Livingston, KY	Crittenden, KY
Union, KY	Sullivan, IN	Knox, IN	

Region 4–Cook County.

Cook

Region 5–Collar Counties.

DuPage	Grundy	Kane	Kankakee	Kendall
Lake	McHenry	Will		

Out of State Counties:

Milwaukee County, WI	Walworth, WI	Kenosha, WI	Lake, IN

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992; added at 38 Ill. Reg. __________, effective _________________)

Section 140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services (Repealed)

~~a) In accordance with Sections 140.464 and 140.930(a), certain providers who serve women will receive enhanced reimbursement rates for the following services:~~

~~CODE~~	~~DESCRIPTION~~
~~W7359~~	~~Prenatal risk assessment~~
~~59409~~	~~Vaginal delivery~~
~~59410~~	~~Vaginal delivery~~

~~59500~~	~~C-section delivery~~
~~59514~~	~~C-section delivery~~
~~59515~~	~~C-section delivery~~

~~b) In accordance with Sections 140.464 and 140.930(a), certain providers who serve children under age 21 will receive enhanced reimbursement rates for the following services:~~

~~CODE~~	~~DESCRIPTION~~
~~W7018~~	~~Healthy kids screening-Chicago Downstate~~
~~W7360~~	~~Risk assessment, child referred for mental health assessment/services~~
~~W7361~~	~~Risk assessment, for mental health services, child, no referral~~
~~W7362~~	~~Risk assessment, for child referred for substance abuse assessment/treatment~~
~~W7363~~	~~Risk assessment for substance abuse, child, no referral~~
~~99201~~	~~Office visit – new patient – brief~~
~~99202~~	~~Office visit – new patient – limited~~
~~99203~~	~~Office visit – new patient – intermediate~~
~~99204~~	~~Office visit – new patient – extended~~
~~99205~~	~~Office visit – new patient – comprehensive~~
~~99211~~	~~Office visit – established patient – brief~~
~~99212~~	~~Office visit – established patient – limited~~

~~99213~~	~~Office visit – established patient – intermediate~~
~~99214~~	~~Office visit – established patient – extended~~
~~99215~~	~~Office visit – established patient – comprehensive~~

~~e) All other visits and services billed under valid CPT-4 procedure codes will be reimbursed at January 1, 1993, rates.~~

(Source: Repealed at 38 Ill. Reg. __________, effective ________________)