

## =Definitions

Effective June 15, 2011

ARS - Alternate Reimbursement System is an inpatient per diem rate based on the hospital's allowable operating cost and other costs reimbursed on a per diem basis, and applicable adjustments.

=All-Inclusive Rate - A specified rate that includes all services provided in an inpatient or outpatient setting for each day a patient is treated. The all-inclusive rate is considered to cover all services provided by salaried hospital personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment, and all X-ray, laboratory and therapy provided to the patient on the same day. Exceptions to this are:

Reimbursement can be made for the professional outpatient service of a physician salaried by the hospital that is involved with direct patient care. This excludes billing for services by radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists.

Occupational or speech therapy, or both, may be billed separately if provided in conjunction with physical rehabilitation services.

Certain covered injectable drugs, including but not limited to Epogen and Aranesp, administered in conjunction with outpatient renal dialysis treatment, are reimbursed as an add-on payment.

[Expensive drugs and devices](#) that are provided in conjunction with a service from the APL may be reimbursable. Refer to the department's Web site for a listing of the applicable drugs and devices codes with their corresponding Ambulatory Procedures Listing (APL) codes.

Procedures provided in an outpatient setting must be included on the APL to be paid at the all-inclusive rate. (For the definition of APL, see below). If the procedure is not included, the service must be billed as fee-for-service.

[Ambulatory Procedures Listing \(APL\)](#) - A listing of procedures that has been determined by the department to be either unique to or most appropriately provided in the hospital outpatient or ambulatory surgical treatment center setting.

Cost-Reporting Hospital - All Illinois hospitals enrolled with the department of Healthcare and Family Services must file Medicaid and Medicare cost reports. All hospitals in states contiguous to Illinois providing 100 or more inpatient days of care to Illinois Medicaid patients, or that elect to be reimbursed under DRG payment methodology, must file Medicaid and Medicare cost reports.

DRG-PPS - Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) method of inpatient reimbursement. This method of reimbursement is calculated on a per discharge basis, and is patterned after Medicare's method of payment.

Emergency Services - Those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the department shall be based on circumstances at the time of initial examination, not upon the final determination of the patient's actual condition, unless the actual condition is more severe.

Emergency Level I (Revenue Code 0450) - Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function. Claims must be billed using one of the specified CPT codes for Emergency Level I services identified in the [APL](#) Group Order document on the Web site.

Emergency Level II (Revenue Code 0456) - Emergency Services that do not meet the definition of Emergency Level I care, but which are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity that urgent or unscheduled care is required. Claims must be billed using one of the specified CPT codes for Emergency Level II services identified in the APL Group Order document at the Web site above.

Non-Emergency/Screening Level (Revenue Code 0451) - Those services provided in the hospital emergency department that do not meet the requirements of Emergency Levels I or II. For such care, the department will reimburse the hospital either applicable current fee for service rates for the services provided **or** a screening fee, but not both. Institutional claims must be billed using a specified CPT code for Non-Emergency/Screening Level services identified in the APL Group Order document at the Web site above.

Fee-for-Service (FFS) - A payment methodology for certain services provided in hospital outpatient settings for which the hospital must conform to the policies and billing procedures for other non-hospital providers of services. Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-hospital-based setting. Medicare crossover claims billed on the institutional claim format are excluded. Refer to Topic H-201.12.

=Hospital-based Organized Clinics – Hospital-based organized clinics must meet the requirements as stated in Ill. Adm. Code Section 140.461(a). This includes being physically located within a 35-mile radius of the main hospital campus as defined in 42 CFR Part 413.65.

Inpatient Services - Those services provided to a patient whose condition warrants formal admission and treatment in a hospital, and that are reimbursed based on the per diem or per discharge all-inclusive rate.

Institutional Claim format - Claims prepared in the 837I or Direct Data Entry (DDE) electronic formats or UB-04 paper claim format.

Long Term Stay Hospital - Hospitals that have an average length of inpatient stay which exceeds 25 days and are determined to provide long term acute care. These hospitals are exempt from the DRG methodology and receive reimbursement under an alternate reimbursement system (ARS) methodology. An example of a service provided by a long term stay hospital is ventilator care. The term "long term stay hospital" does not include a psychiatric, rehabilitation, or children's hospital.

National Drug Code (NDC) - A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. The National Drug Code (NDC) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

National Provider Identifier (NPI) - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers, payees, and health plans. For healthcare providers and payees, this identifier is referred to as the National Provider Identifier (NPI).

Non-Cost Reporting Out-of-State Hospital - A hospital in a state other than Illinois that is not required to file Medicaid and Medicare cost reports with the department. Non-cost reporting out-of-state hospitals are exempt from DRG payment methodology.

Psychiatric Clinic Type A Services - Type A psychiatric clinic services are clinic services packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional electroconvulsive therapy (ECT); and counseling, provided in the hospital clinic setting. Claims must be billed using one of the specified procedure codes for Psychiatric Clinic Type A services identified in the [APL](#) Group Order document on the Web site.

Psychiatric Clinic Type B Services - Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12-month period. Claims must be billed using a specified procedure code for Psychiatric Clinic Type B services identified in the [APL](#) Group Order document.

SASS - Screening, Assessment and Support Services (SASS) program. This program is a result of the Children's Mental Health Act of 2003, which requires the Department of Healthcare and Family Services (HFS) to ensure that all eligible children and adolescents receive a screening and assessment prior to any admission to a hospital for inpatient psychiatric care. Refer to Topic H-268 for additional information.

**=H-201.26 Psychiatric Ambulatory Services – Categories of Service 27 and 28***Effective June 15, 2011*

To be eligible for the provision of psychiatric ambulatory services, a hospital may request to enroll for Type A and/or Type B psychiatric ambulatory services when they are enrolled for inpatient psychiatric services. Additionally, a hospital that was previously enrolled with the department for the provision of inpatient psychiatric services on or after June 1, 2002, but is no longer enrolled, may request to be enrolled for ambulatory psychiatric services only. The hospital must, as stated in Ill. Adm. Code Section 140.461(a):

1. Have a hospital-based organized clinic with 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 the following requirements:
  - Be adjacent to or on the premises of the hospital and be licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or
  - Have provider-based status under Medicare pursuant to 42 CFR 413.65; or
  - Be clinically integrated as evidenced by the following: 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
  - Be fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic; and
  - Be held out to the public and other payers as part of the main hospital; and

- Be operated under the ownership and control of the main hospital, as evidenced by the following: the business 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
- Be located within a 35 mile radius of the main hospital campus as defined in 42 CFR Part 413.65.

4. Meet the applicable requirements of 89 Ill Adm. Code 148.40(d) for Psychiatric Clinic services.

To enroll for the provision of psychiatric ambulatory services, a hospital must request the Psychiatric Ambulatory Services Type A and B Enrollment Assurances Form. This form and a copy of the entire enrollment packet must be sent by the hospital to the Department of Human Services for approval. The address is:

Illinois Department of Human Services  
Division of Mental Health  
319 East Madison, Suite 3B  
Springfield, Illinois 62701

If a hospital is already enrolled with the department, and later wants to add psychiatric services to its billable categories of service, the hospital must contact the Provider Participation Unit.

### **H-201.27 Physical Rehabilitation Ambulatory Services – Category of Service 29**

A hospital may request to enroll for physical rehabilitation ambulatory services when they are enrolled for Inpatient Physical Rehabilitation Services. To be eligible for the provision of Physical Rehabilitation Ambulatory Services, the rehabilitation facility must comply with the requirements of Items 1, 2, and 3 of Topic H-201.26, and 89 Ill. Adm. Code Section 148.40(d) for Rehabilitation Clinic services.

### **H-201.3 Participation Approval**

When participation is approved, the hospital will receive a computer-generated notification, the Provider Information Sheet, listing all data on the department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix H-1.

If all information is correct, the hospital is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the department files. If any of the information is incorrect, refer to Topic H-201.5.

Except for Category of Service 24, base rates will be shown on the Provider Information Sheet. Payment for Category of Service 24 is based upon the applicable outpatient-billable procedure code from the Ambulatory Procedures Listing (APL) or the applicable revenue code for emergency department or observation services.

When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. In instances in which a hospital has more than one associated renal dialysis facility, a separate Provider Information Sheet will be sent for each unit. In those instances in which a dialysis facility is located within another hospital, and the cost is allowed to the parent hospital, a separate enrollment is generated for that facility. The payee may be either the parent hospital or that facility's office. A separate Provider Information Sheet will be produced for the facility.

In instances in which two or more hospitals have the same FEIN number, but the entity owning the hospitals has separate Medicare certifications for those hospitals, the hospitals will be enrolled separately and a Provider Information Sheet will be prepared for each location showing the unique HFS provider number assigned. Appropriate data, as indicated above, will be listed for all categories of service that may be provided at the specific location.

If two or more hospitals are certified under a single Medicare number, the hospitals must be enrolled as a single hospital in the Medical Assistance Program (see 89 Ill. Adm. Code Section 140.11). This excludes children's hospitals as defined in 89 Ill. Adm. Code Section 149.50 (c)(3).

#### **H-201.4 Participation Denial**

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after the date of this notice, the hospital may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

## H-201.5 Provider File Maintenance

The information carried in the department's files for participating providers must be maintained on a current basis. The provider and the department share responsibility for keeping the file updated.

### Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the department is to be notified. When possible, notification should be made in advance of a change.

**Procedure:** The provider is to lineout the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Healthcare and Family Services  
Provider Participation Unit  
Post Office Box 19114  
Springfield, Illinois 62794-9114

**Failure of a provider to properly notify the department of corrections or changes may cause an interruption in participation and payments.**

### Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, the department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

### **H-250.33 Medicaid High Volume Adjustment (MHVA)**

All hospitals receiving MPA payments, with the exception of hospitals operated by the University of Illinois, the Cook County Bureau of Health Services, and the state-operated psychiatric hospitals receive an additional per diem payment known as the Medicaid High Volume Adjustment Payment. This per diem payment is added to the hospital's inpatient DRG or per diem payments.

### **H-250.34 Outliers**

Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units not reimbursed under the DRG-PPS. These adjustments are determined and paid in accordance with department rules in 89 Ill. Adm. Code 148.130.

Under 89 Ill. Adm. Code 148.130, disproportionate share hospitals that are not reimbursed under the DRG-PPS may be eligible for outlier adjustments for exceptionally costly stays provided to children under the age of six.

Hospitals that do not meet the definition of a disproportionate share hospital may be eligible for outlier adjustments for exceptionally costly stays provided to children under the age of one.

Children's hospitals, as defined in 89 IL Admin. Code section 149.50(c)(A), are eligible to receive outliers on claims for children through the age of 18 effective with admissions on or after January 1, 2008. Children's hospitals, as defined in 89 IL Admin. Code section 149.50(c)(B), are eligible to receive outliers on claims for children through the age of 18 effective with admissions on or after July 1, 2009.

Outlier adjustments are also provided for exceptionally costly or lengthy stays provided by hospitals reimbursed under the DRG-PPS. Outlier adjustments for exceptionally costly or lengthy stays provided by hospitals reimbursed under the DRG-PPS are determined and paid in accordance with department rules in 89 Ill. Adm. Code 149.105.

### **H-250.4 Quarterly Adjustments to Payments**

Quarterly adjustments are identified and reimbursed in accordance with 89 Ill. Adm. Code section 148.

### **=H-250.5 Outpatient Payment Methodologies**

*Effective June 15, 2011*

The all-inclusive APL rate is considered to cover all services provided by salaried hospital personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment, and all X-ray,

laboratory and therapy provided to the patient on the same day. Exceptions to this are:

- Hospitals are allowed to bill separately on a fee-for-service basis for a salaried physician providing direct patient care. This claim must be billed under the salaried physician's name and NPI (see Topic H-270.21 for additional information):
- Occupational and/or speech therapy services provided in conjunction with physical rehabilitation services may be billed fee-for-service;
- Chemotherapy services provided in conjunction with radiation therapy may be billed fee-for-service.

An outpatient claim must contain at least one procedure code or an emergency department or observation revenue code as listed in the APL. **When any service listed in the APL is performed on a given day, all services provided on that day (excluding the exceptions above) must be billed on a single outpatient institutional claim.**

However, if during the same treatment span, subsequent to emergency department or observation services, the patient is admitted to the hospital as an inpatient, only the emergency room charge **or** the observation service may be billed on the outpatient claim. It is up to the hospital to determine which outpatient service will provide greater reimbursement. Charges incurred as a result of services provided by other outpatient departments prior to the patient's admission, such as laboratory or radiology services, are to be shown on the inpatient claim.

Reimbursement for outpatient services is based upon the rate of the highest-paying procedure code (or emergency department or observation services revenue code) listed on the claim.

## **=H-270 Ambulatory Services**

*Effective June 15, 2011*

Ambulatory services are defined as preventive, diagnostic, therapeutic, rehabilitative or palliative services provided in an ambulatory setting by or under the direction of a licensed practitioner. Ambulatory services include all services that do not require the formal admission of a participant to a hospital, including services provided in hospital outpatient departments, clinics as defined in Ill. Admin. Code section 140.461(a), and Ambulatory Surgical Treatment Centers (ASTCs).

Emergency, observation and referred services are to be provided in an ambulatory setting. Ambulatory services are reimbursed by the department at the appropriate rate in the appropriate manner for the setting in which the care is given, i.e., fee-for-service or all-inclusive rate (for Ambulatory Procedures Listing services).

Unless a service is on the Ambulatory Procedures Listing (APL), all services currently provided in the hospital outpatient setting are subject to the fee-for-service payment methodology. This means that for these services, hospitals will be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting; no separate facility fee will be paid. The appropriate handbook for the type of service provided should be referenced for billing of these services.

**NOTE** - Institutional Medicare crossover claims are excluded from the fee-for-service billing methodology. A claim that has been totally rejected for payment by Medicare may be submitted for payment consideration only when the reason for nonpayment is either that the patient was not eligible for Medicare benefits or the service is not covered as a Medicare benefit. In such instances, the department is to be billed only after final adjudication of the claim by the Medicare carrier or intermediary. The claim should be submitted according to Medicaid billing requirements.

### **H-270.1 Ambulatory Procedures Listing (APL)**

Certain procedures provided in the outpatient hospital or ambulatory setting which have been determined by the department to be either unique to or most appropriately provided in those settings are contained in the Ambulatory Procedures Listing (APL).

The [APL](#) is available on the department's Web site. The procedures are grouped and subgrouped as follows:

**Group 1 - Surgical Groups**

- a) Surgical Group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment.
- b) Surgical Group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency department treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment.
- c) Surgical Group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency department and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons.
- d) Surgical Group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency department, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. Certain dental procedures performed by dentists are included in this group. However, a patient must meet the following criteria in order for dental procedures to be performed in the outpatient setting:
  - 1) Requires general anesthesia or conscious sedation;
  - 2) Has a medical condition that places the patient at an increased surgical risk, such as, but not limited to: cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or
  - 3) Patient cannot safely be managed in an office setting because of a behavioral, developmental or mental disorder.

**Group 2 - Diagnostic and Therapeutic Groups**

- a) Diagnostic and Therapeutic Group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician.
- b) Diagnostic and Therapeutic Group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study.

There are three (3) levels of observation billing, based upon the number of hours that the patient is actually in observation. All observation services are billed using Revenue Code 0762, and the number of hours in observation is indicated in Service Units. **The department will not reimburse for observation services of less than one hour.** The levels are as follows:

Observation Time Period	Units Billed
1 hour through 6 hours, 30 minutes	1 through 6
6 hours, 31 minutes through 12 hours, 30 minutes	7 through 12
12 hours, 31 minutes or more	13 or more

The hospital may bill for both observation and other APL procedures, but will be reimbursed only for the service with the highest rate of payment. Observation services must be billed using one of the CPT codes identified in the [APL](#) Group Order document on the Web site.

#### H-270.4 Psychiatric Clinic Services

The two categories of ambulatory psychiatric services for which the department provides payment to appropriately enrolled hospitals are: Psychiatric Clinic Services, Type A (COS 27) and Psychiatric Clinic Services, Type B (COS 28). See Topic H-201.26 for specific enrollment information for these categories.

Except for children eighteen (18) years of age or younger in Family and Children Assistance cases in the city of Chicago, psychiatric services are not covered services for participants of Family and Children Assistance (Category 07).

For patients of categories of assistance other than Category 07, ambulatory psychiatric services may be provided by a hospital that is enrolled to provide the appropriate type of ambulatory psychiatric service.

Reimbursement is in accordance with procedures provided in the Ambulatory Procedures Listing (APL). Psychiatric clinic Type A and B services must be billed using one of the specified procedure codes identified in the [APL](#) Group Order document on the Web site.

##### =H-270.41 Type A Services

*Effective June 15, 2011*

The department defines Type A ambulatory psychiatric services as an ambulatory service package consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling.

Services are reimbursed at the all-inclusive rate approved by the department. This rate is considered by the department to include services provided by salaried hospital personnel (except as noted in this section), all drugs administered and/or provided for home use and all equipment, drugs and supplies used for diagnostic and/or treatment purposes during the ambulatory visit.

#### **H-270.42 Type B Services**

Type B ambulatory psychiatric services are defined by the department as an active treatment program in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four (4) hours per day at a minimum of three (3) half days of active treatment per week. The duration of an individual patient's participation in the Ambulatory Psychiatric Services, Type B, treatment program is limited to six (6) months in any twelve (12) month period.

When Type B services have been provided, the reimbursement is made at the all-inclusive rate approved by the department. This rate is considered by the department to include services provided by salaried professional and ancillary personnel (except as noted in this section) and any expenses incurred for supplies and materials, etc., in the provision of the services.

#### **=H-270.5 Physical Rehabilitation Services**

*Revised June 15, 2011*

Except for children eighteen (18) years of age or younger in Family and Children Assistance cases in the City of Chicago, ambulatory physical rehabilitation services are not covered services for participants enrolled in the Family and Children Assistance (Category 07) program.

Ambulatory services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an ambulatory basis.

Reimbursement for ambulatory physical rehabilitation procedures in the Ambulatory Procedures Listing (APL) is based on the all-inclusive rate in effect on the date of service.

The all-inclusive rate is considered by the department to cover services provided by salaried hospital personnel (except the services of a salaried physician involved with direct patient care, as noted under Topic 270.21), all drugs administered and/or provided for take home use, all equipment and supplies used for diagnostic and/or treatment purposes, and all X-ray, laboratory, and therapy services (except occupational and/or speech therapy; see Definitions, Page vi) provided to a patient on the same day as the ambulatory visit.

Unless medical supplies and equipment, braces and prosthetic devices are provided in conjunction with an APL service, prior approval may be needed. See the Handbook for Providers of Medical Equipment and Supplies for further information.