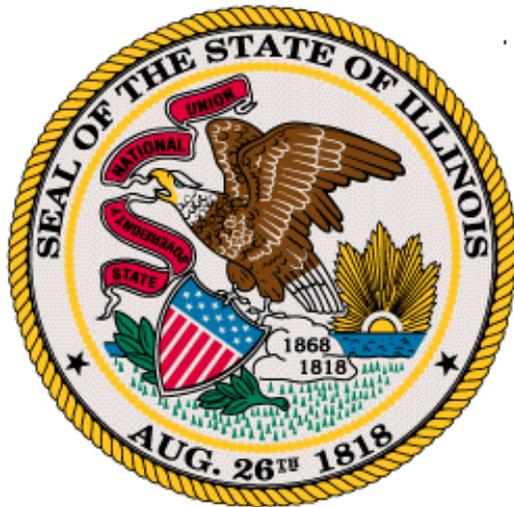


# Illinois Department of Healthcare and Family Services

Practitioner Billing Webinar

July 21, 2016



# What's New at HFS?



- IMPACT Updates
- Postpartum Visits and Perinatal Care Transition
- Prior Approval for Children's Physical and Occupational Therapy Services
- Health Alliance Medicare-Medicaid Alignment Initiative (MMAI)
- Care Coordination Health Plan Transitions for ACE and CCE Enrollees
- Managed Care Manual
- Revision of Form HFS 1409 Prior Approval Request and Availability
- Publication of Public Notices on Healthcare and Family Services Website
- Change to Procedure Code for billing Emergency Contraceptive Pills (ECPs)
- Hospital Fee-For-Service Billing for Electrocardiograms and Visit Codes
- Handbook Updates

# IMPACT

## Enhancement to Allow The Provider to Enter A Remittance Address

- Please refer to the October 28, 2015 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151028a.aspx>
- Beginning December 12, 2015 the Enrollment system was modified allowing enrollment of **Typical** or **Atypical** Sole Proprietor, Group, Facility/Agency/Organization(FAO) or Atypical Agency with multiple NPI's (National Provider Identifiers) to enter an optional address termed the **Remittance Address**
- If a Remittance Address was not entered, then the provider's payments and remittance advices will be directed to the Pay to Address listed for that TIN
- If a Remittance Address is entered it is important to note there may only be one per IMPACT enrollment no matter the number of locations listed in that enrollment.
- In summary, the IMPACT Remittance Advice modification allowed providers using one TIN, but having multiple NPI's, to have their own address for the routing of payments and remittance advices
- Providers had previously been informed that the Pay To Address in IMPACT would be used to update all Legacy Payees with the same TIN; however, this did not happen until after January 1, 2016.

# IMPACT

## Provider Revalidation Due Date Extensions

- Please refer to the March 15, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160315a.aspx>
- The Center for Medicare and Medicaid Services (CMS) has extended the due date for all Medicaid Providers to revalidate to September 24, 2016
- Facility/Agency/Organizations (FOAs) revalidation was extended to June 30, 2016
- HFS further extended the revalidation due date for Individual/Sole provider to August 31, 2016
- Failure to submit a provider's enrollment for revalidation and approval will result in disenrollment from Illinois Medicaid on September 25, 2016. ***All providers are encouraged to revalidate as soon as possible to ensure their application is approved by the due date.***

# IMPACT

## Provider Type Selections

- Please refer to the March 15, 2016 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513a.aspx>, which reminded providers to select **ALL** correct Specialty/Subspecialty combinations upon completion of the initial application or revalidation in the IMPACT system.
- It is important to make the correct selection in order to be reimbursed for all categories of services currently provided to Medicaid participants
- Claims that are submitted with information that is different from the most recent provider information sheet may be delayed in processing or rejected
- Separate applications have been completed by providers for each specialty/subspecialty causing the system to generate additional provider ID numbers resulting in rejections of claims because the system does not recognize them
- A table of IMPACT Provider Types, Specialties and Subspecialties may be found on the [IMPACT website](#), which also provides important information for providers who may have questions regarding these issues

# IMPACT

## Provider Enrollment Data Exchange

- Please refer to the May 13, 2016 provider notice at: <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513b.aspx> regarding the transferring of data from the IMPACT enrollment system into the system that processes provider claims known as the Legacy Medicaid Management Information System (MMIS)
- Provider information sheets are mailed to providers at the office address on file and to all “payee addresses” if different from the office address
- Providers are responsible for reviewing all information for accuracy or risk a delay in claim processing or rejections
- It is critical for payment of claims that the provider name matches the “Doing Business As” name in IMPACT
- Do not change the historical provider name submitted on claims to match the “Doing Business As” name in IMPACT until you have received the provider information sheet from HFS

# IMPACT

## New Rendering/Service Provider

- Please refer to the July 7, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160711a.aspx>
- Once the revalidation process has been completed, new rendering/service providers will be required to enroll in IMPACT whom have not been previously required to enroll as a provider with Illinois Medicaid
- The Department will notify providers when these types of rendering/service providers need to begin the enrollment process via a provider notice posted on the IMPACT website
- For additional information, including frequently asked questions, webinars and other training guides, please visit the [IMPACT website](#)

# IMPACT

## Claims Processing for New and Revalidating Providers

- Please refer to the June 23, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160623b.aspx>
- Although new providers whose enrollment has been approved in IMPACT will receive an email welcoming them as a Medical Assistance Provider, information from the IMPACT enrollment system must be transferred to the legacy system (MMIS) prior to billing. This could take up to two weeks.
- Once the Department has transferred data from the IMPACT system to the legacy system (MMIS), a Provider Information Sheet will be generated and sent to the Pay to Address
- Prior to billing providers should review the Provider Information Sheet to verify that everything is correct. If correct, claims may then be submitted.
- Providers must request a time override for any claims that are out of timely. ***Only claims that could not be billed until enrollment, re-enrollment, addition of a new specialty/sub-specialty, or payee addition was complete are eligible for time override for 180 days from the update recorded on the provider file.*** For instructions on how to request a time override please refer to the Timely Filing Override Submittal instructions found at:  
<http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx>.
- If you have additional questions or need assistance, please contact the IMPACT Help Desk:
  - By email: [IMPACT.Help@Illinois.gov](mailto:IMPACT.Help@Illinois.gov)
  - By phone: (877) 782-5565 Select option #1

# Postpartum Visits and Perinatal Care Transitions

- Please refer to the September 29, 2015 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150929a.aspx>
- Care transition is the movement of patients from one health care practitioner or setting to another as their condition and care needs change, ensuring coordination and continuity of care
- The postpartum visit should be scheduled or confirmed prior to hospital discharge and discharge instructions should include the appointment date, time and location
- The postpartum visit allows for a physical exam, supportive guidance on healthy behaviors, assessment of health conditions, including depression, preconception counseling, and reproductive life planning, including discussion/initiation of birth control, if not previously initiated
- Reimbursement is allowed for one comprehensive postpartum visit with additional visits for related issues outside the routine postpartum visit, which are payable if supported with appropriate coding/documentation
- The postpartum provider should ensure that women are linked back to their primary care provider (PCP) after the postpartum visit which is especially important if the patient has other medical conditions, complications during pregnancy, or pre-existing co-morbidities
- If the PCP is unknown please review the a “Quick Reference Tool” link provided as an attachment to the Provider Notice in identifying the patient’s PCP

# Prior Approval for Children's Physical and Occupational Therapy Services

- Please refer to the November 23, 2015 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151023b.aspx>
- As a result of *Public Act 098-0651*, the Department is required to prior approve **all adult and child therapy services** for medical necessity
- The Department implemented prior approval for medical necessity of physical and occupational therapy for children through age 20 effective with dates of service on or after November 16, 2015
- Home health agencies must submit the following information for each prior approval:
  - HFS 1409 (pdf) Prior Approval Request Form
  - Practitioner Order
  - Therapist Initial Evaluation
  - HCFA 485 Plan of Care
- Outpatient therapy providers must submit the following information for each prior approval:
  - HFS 3701T (pdf) Therapy Prior Approval Request Form
  - Practitioner Order
  - Therapist Initial Evaluation
  - Plan of Care

***\*Initial Requests and renewal requests may be faxed to (217) 524-0099***

***\*\*Reviews and additional information may be faxed to (217) 558-4359***

# Prior Approval for Children's Physical and Occupational Therapy Services (cont'd)

- Children age birth to three may be eligible to receive their physical and/or occupational therapy services through the Illinois Early Intervention (EI) Program, administered by the Department of Human Services
- Developmental screening should first be conducted by the medical provider at priority intervals at the 9 month and 18 month visit, and the 24 month and/or 30 month visit. Further guidance regarding objective developmental screenings is in Section HK-203.5 of the Handbook for Providers of Healthy Kids Services at:  
<http://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf>
- Screening tools can be found in the appendices in the Handbook for Providers of Healthy Kids Services at:  
<http://www.illinois.gov/hfs/SiteCollectionDocuments/hk200a.pdf>

# Health Alliance Medicare-Medicaid Alignment Initiative (MMAI)

- ▶ Please refer to the November 29, 2015 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151029a.aspx>
- ▶ Health Alliance is no longer be part of the MMAI program effective January 1, 2016. Options for enrollees included enrollment with Molina Healthcare of Illinois by contacting Client Enrollment Services at 877-912-8880 (TTY 866-565-8576) or enrollment in a Medicare Advantage Plan.
- ▶ Enrollees who did not opt-in to Molina's MMAI plan or in a Medicare Advantage plan were automatically enrolled in fee-for-service Medicaid and original Medicare with Part D plan effective January 1, 2016. For more information enrollees should contact Medicare at 800-633-4227, and (TTY 877-468-2048)

***\*Please note that Health Alliance Connect will continue to be offered to Family Health Plan (FHP) and Integrated Care plan (ICP) enrollees. Only the Health Alliance Connect MMAI plan has terminated.***

# Care Coordination Health Plan Transitions for ACE & CCE Enrollees

- ▶ ACEs and CCEs are in the process of either becoming Managed Care Community Networks (MCCNs) or partnering with MCOs to provide care coordination services within risk-based managed care delivery systems
- ▶ The Department anticipated all ACE and CCE transitions to be complete by July 1, 2016, however some partnerships are still being finalized.
- ▶ Please refer to the January 4, 2016 provider notice for a list of Health Plans that have partnered with the ACE and CCE plans:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160104a.aspx>

# Managed Care Manual

- Please refer to the January 19, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160119a.aspx>
- A link to the manual is provided in the notice
- The manual contains information regarding the Medicaid Managed Care Program and is not intended to supersede, modify or replace any policies, guidelines, or other provider handbooks applicable to providers in the Medical Assistance Program under the fee-for-service payment system.

# Revision of Form HFS 1409 Prior Approval Request

- The Department has recently reformatted the HFS 1409 Prior Approval Request Form. There are no changes to the content of the form.
- The new version is available in a PDF-fillable format on the Medical Forms Page at:  
<http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx>
- The Department will no longer stock a paper version for ordering from the warehouse providers must print off the website version for submission
- Please refer to the January 26, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160126a.aspx>

# Publication of Public Notices on HFS Website

- Please refer to the March 18, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160318b.aspx>
- The Centers for Medicare and Medicaid Services (CMS) published final rules designed to ensure that States' fee-for-service Medicaid payments comply with the access standards outlined in Section 1902(a)(30)(A) of the Social Security Act (SSA)
- This new rule recognizes electronic publications posted on the Medicaid state agency's web site as an acceptable form of public notice
- The Department has developed a webpage on the HFS web site for the purpose of providing public notice of proposed changes in methods and standards for setting payment rates for services. A link to the public notices can be found under the "Stay Informed" section located at the bottom left hand corner of the HFS Home Page at: <http://www.illinois.gov/hfs/Pages/default.aspx>

# Change to Procedure Code for Billing of Emergency Contraceptive Pills (ECPs)

- ▶ Please refer to the April 29, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160429a.aspx>
- ▶ Effective with dates of service June 1, 2016, all emergency contraceptive pills (ECPs) must be billed using procedure code J8499 to allow proper reimbursement to providers
- ▶ Effective with dates of service June 1, 2016 the Department will no longer reimburse ECPs billed with procedure code S4993

# Hospital Fee-For-Service Billing for Electrocardiograms (ECG/EKG) and Visit Codes

- ▶ Please refer to the June 30, 2016 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160630b.aspx>
- ▶ Effective with dates of service on and after July 1, 2016 hospitals may bill the technical component CPT code for an ECG procedure (tracing only, without interpretation and report) as a fee-for-service charge in the hospital outpatient setting
- ▶ The professional component CPT code for an ECG procedure (interpretation and report only) must be billed under the name and NPI of the practitioner performing that service
- ▶ The global CPT code for an ECG procedure (routine ECG with at least 12 leads; with interpretation and report) should *not* be billed by hospitals or practitioners in the hospital outpatient setting
- ▶ As a reminder, evaluation and management codes are not allowable fee-for-service charges by hospitals with the exception of CPT code 99211 with the “TH” modifier, which may be billed for OB triage when there is no billable APL service

# Handbook Updates



- ▶ Chapter E-200, Audiology Handbook – reissued May 2016
- ▶ Chapter B-200, Chiropractor Handbook – reissue COMING SOON
- ▶ Chapter L-200, Handbook for Laboratory Services – reissued May 2016
- ▶ Chapter F-200, Podiatry Handbook – reissue COMING SOON
- ▶ Chapter A-200, Practitioner Handbook – reissue COMING SOON
- ▶ Chapter J-200, Therapy Services Handbook – reissued July 2016

# ICD - 10

- Please refer to the June 17, 2015 provider notice concerning the ICD-10 Implementation – Claim Submission Requirements which includes FAQs at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150617a.aspx>, with a reminder follow up notice dated October 5, 2015 at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151005a.aspx>
- The conversion from ICD-9-CM code set to ICD-10-CM code set as federally mandated was effective October 1, 2015
- HFS will reject claims that are billed with both ICD-9-CM and ICD-10-CM diagnosis codes on the same claim
- ICD-9-CM diagnosis codes will no longer be accepted on electronic and paper claims with service dates on or after October 1, 2015
- The department has revised the following paper claim forms to accommodate ICD-10-CM diagnosis coding which will have a revision date of **R-2-15** in the bottom left corner of the form
  - HFS 2210 – DME equipment and supplies
  - HFS 2211 – Laboratory/Portable X-ray
  - HFS 2212 – Health Agency

# Home Health Care Services

- The Department has reissued the Chapter R-200, Handbook for Home Health Agencies:  
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx>
- Please refer to the May 3, 2016 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160503b.aspx> regarding Home Health coding and billing changes effective January 1, 2016
- Coding Changes:
  - Effective January 1, 2016 HCPCS G0154 become obsolete and was replaced with two new codes: **G0299** for direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting and **G0300** for direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting. The code for Certified Nurse Aide (CNA) remains G0156.
- Billing Changes:
  - Effective January 1, 2016 claims for G0299, G0300 and G0156 must be submitted for each date of service
  - The total number of service hours per date of service should be reported in the Units/Quantity field
  - The Provider Charge/Line Item Charge Amount is the approved hourly rate multiplied by the number of hours for that service

# Home Health Care Services Reminder

## ➤ Face-To-Face Requirement

- Dates of service beginning January 1, 2014 the Department requires that the initial certification of Home Health intermittent skilled nursing services and/or therapy services include documentation that a face-to-face encounter was conducted by the practitioner ordering the home health services
- Please refer to the December 11, 2013 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131211a.aspx> for further information and details regarding the conditions that must be met during the face-to-face encounter

## ➤ Rate Change

- As a result of Senate Bill 741, the Department increased the rates paid to Home Health Agencies for all-inclusive intermittent visits, and for In-Home shift hourly nursing services rendered by a Certified Nursing Assistant (CNA), effective July 1, 2014
- Please refer to the October 2, 2014 provider notice at: <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141002a.aspx>

# Family Planning

- **Dispensing fee for certain 340B purchased birth control methods**
  - Effective July 1, 2014 the dispensing fee for family planning methods purchased through the 340B federal Drug Pricing Program was increased to \$35.00
  - Providers must identify 340B purchased drugs by reporting modifier “UD” in conjunction with the appropriate procedure code
  - The provider charge should be the actual acquisition cost plus the \$35 dispensing fee
- **Vaginal Ring, Contraceptive Patch and Oral Contraceptives**
  - Providers must dispense the three (3) month supply allowable by the Department whenever possible
  - Exceptions may be made when medically contraindicated and documented in the patient’s medical record
  - Please ensure medical records document the reason for NOT dispensing the required three (3) month supply
- **Hospital Billing & Reimbursement for Immediate Postpartum Long-Acting Reversible Contraceptives (LARCs)**
  - Effective July 1, 2015 hospitals may be reimbursed for long-acting reversible contraceptives (LARCs) provided immediately postpartum in the inpatient hospital setting
  - Payment will be made in addition to the Diagnostic Related Group (DRG) reimbursement for labor and delivery and based on the current practitioner fee schedule
  - The device, HCPCS code, and associated NDC numbers in addition to the billing instructions can be referenced in the June 30, 2015 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150630a.aspx>
  - Practitioners not salaried by the hospital may bill the appropriate Current Procedural Terminology (CPT) code for the LARC insertion in addition to their delivery charges

# Senate Bill 741

## Medicaid Benefit Changes

- Details may be found on the HFS website at:  
<http://www.illinois.gov/hfs/info/factsfigures/Pages/SB741FactSheet.aspx>
- Restoration of coverage for dental care services for adults to that prior to the SMART Act effective July 1, 2014
- Restoration of coverage for podiatry services for adults effective October 1, 2014. Coverage for podiatry services for adults is no longer limited to participants with a primary diagnosis of diabetes.
- Elimination of the prior authorization requirement under the four prescription policy for anti-psychotic drugs effective July 1, 2014
- Elimination of the prior authorization requirement under the four prescription policy for children with complex medical needs who are enrolled in CCE solely to coordinate care for these children, if the CCE has a comprehensive drug reconciliation program, effective July 1, 2014
- Elimination of the annual 20 visit limit for speech, occupational and physical therapies effective October 1, 2014
- Prior approval is required for all participants, occupational and physical therapies effective November 16, 2015
- Speech for children does not require prior approval through the age of 20

# Adult Dental Coverage



- Please refer to the June 26, 2014 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140627>
- Effective July 1, 2014, coverage for adult dental services was restored to that prior to the SMART Act
- Pregnant women (prior to the birth of their children) are eligible for the following five preventive dental services in addition to the dental benefits listed for all eligible adults:
  - Periodic Oral Evaluation
  - Cleaning
  - Periodontal Scaling and Root Planing-4 or more teeth per quadrant
  - Periodontal Scaling and Root Planing-1-3 teeth per quadrant
  - Full Mouth Debridement

# Tobacco Cessation Counseling Services



- Please refer to the August 26, 2014 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140826a.aspx>
- Tobacco cessation counseling services for eligible participants may be a separately billable service under the following procedure codes:
  - 99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
  - 99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
- Counseling sessions must be provided by, or under the supervision of, a physician or any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services

# Tobacco Cessation Counseling Services (cont'd)

## Duration of Counseling

- For pregnant and up to 60-day post-partum women age 21 and over
  - A maximum of three quit attempts per calendar year
  - Up to four individual face-to-face counseling sessions per quit attempt
  - The 12 maximum counseling sessions include any combination of the two procedure codes identified in the previous slide
- Children through age 20 are not restricted to the maximum twelve counseling sessions

# Tobacco Cessation Counseling Services (cont'd)

## Pharmacotherapy

- The Department covers nicotine replacement therapy in multiple forms, as well as two prescription medications indicated for use as an aid to smoking cessation
- Please refer to the Drug Prior Approval webpage for specific drug coverage and prior approval requirements. This link may be found at:  
<http://ilpriorauth.com/>
- Nicotine replacement duration of therapy is normally limited to three months in a year; however, duration limitations may be overridden by the department through the prior approval process on an individual patient basis
- To request prior approval for a specific drug please refer to the link at:  
<http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/DrugPriorApprovalInformation.aspx>

# Annual Medical Cards

- Please refer to the January 30, 2013 provider notice at:  
<http://www.hfs.illinois.gov/assets/013013n.pdf>
- ***Providers should verify medical eligibility at each visit or risk non-payment***
- Providers may not charge participants to verify eligibility
- If the individual provides a Medical Card, Participant Identification Number (RIN), or Social Security number and date of birth, providers may verify eligibility through one of the following resources:
  - MEDI Internet site at:  
<http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx>  
*\*\*when using MEDI be sure to scroll down to view possible MCO enrollment\*\**
  - The REV system. A list of vendors is available at:  
<http://www.illinois.gov/hfs/MedicalProviders/rev/Pages/default.aspx>
  - The Automated Voice Response System (AVRS) at 1-800-842-1461

# Four Prescription Policy



- HFS has reduced the number of prescriptions that can be filled in a thirty-day period, without prior authorization, to four. Information regarding this policy is posted on the web site at:  
<http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx>
- Exceptions to the prescription policy will be allowed in certain situations, with prior approval. As a reminder, effective July 1, 2014 Senate Bill 741 eliminated the prior authorization requirement anti-psychotic drugs and for children with complex medical needs enrolled in a CCE solely to coordinate their care.
- A prior approval request for exception can be initiated electronically on the MEDI system. Please refer to the September 4, 2012 informational notice entitled Drug Prior Approval/Refill Too Soon Entry System), posted on the web site at  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120904b.aspx>
- Effective with the December 10, 2013 provider notice at  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131210a.aspx>, the Department will not require prior approval or four prescription policy overrides for anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder according to Department records

# Changes to Illinois Hemophilia Program

- Effective with dates of service on or after September 1, 2012, HFS began reimbursing services provided to participants in the Illinois Hemophilia Program at the Department's standard reimbursement rates
- As a result, services were no longer reimbursed at the provider's billed charges
- The Illinois Hemophilia Program no longer offers additional coverage for primary care physician visits to qualifying participants due to cancellation of the federal waiver program
- Effective January 1, 2014 a patient's primary insurance may begin to cover the costs currently covered through the State Hemophilia Program. In accordance with Public Act 98-0104, patients must meet their obligations and may be required to obtain and provide proof of health coverage to the Department. Payment of a tax penalty for not obtaining insurance does not meet the requirement. **The Department notified current participants by letter regarding changes.** Please refer to the December 27, 2013 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131227a.aspx> for more information and the provider contact number.

# Submittal of Claims for Multi-Use Vials

- Please refer to the November 10, 2014 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141110a.aspx>
- When billing the Department for a multi-use vial, providers must bill only for the quantity of the drug actually dispensed
- Claims submitted for an entire vial, when a partial vial was used are subject to audit and/or recoupment of any payment made for the unused portion of the medication

# Sexual Assault Emergency Treatment Program

- Effective with dates of service on or after July 1, 2012, HFS began reimbursing all services provided to survivors of a sexual assault through the Sexual Assault Emergency Treatment Program at the Department's standard reimbursement rates, including follow-up care
- For details and billing instructions please refer to the June 29, 2012 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120629b.aspx>
- Hospitals must register all non-Medicaid sexual assault patients in the MEDI Early Registration of Sexual Assault Survivor's System and issue follow-up Authorization for Payment Vouchers for direct payment to service providers - all providers should include a copy of this authorization with their claim

# Services to Hospice-Enrolled Participants

- Effective with dates of service on or after July 1, 2012, some services are no longer covered for non-hospice providers serving patients enrolled in the Department's hospice program
- These restrictions do not apply to Medicare recipients or participants under age 21 years
- For details and a complete list of non-covered services please refer to the June 27, 2012 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120627a.aspx>
- These restrictions do not affect services provided and billed by the hospice agency
- Exception: Physician and APN services will be reimbursed only if the service is not related to the terminal illness, identified on a claim by applying the GW modifier to the procedure code

# Chiropractic Services

- Effective with dates of service on or after July 1, 2012, HFS eliminated chiropractic services for participants 21 years of age and older
- For details please refer to the June 30, 2012 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120629a.aspx>
- Participants under the age of 21 will continue to receive coverage for spinal manipulation procedures to correct subluxations *of the spine only*
- Claims for participants under the age of 21 must include a diagnosis of spinal subluxation at the applicable level and an allowable procedure code from the Chiropractic Fee Schedule located at  
<http://www.illinois.gov/hfs/SiteCollectionDocuments/070112chiro.pdf>

# Group Psychotherapy

- Effective with dates of service on or after July 1, 2012, HFS eliminated coverage of group psychotherapy for participants who are residents in a nursing facility, including a nursing facility classified as an institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act
- For details please refer to the provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120627b.aspx>
- Per the July 23, 2012 addendum to the June 27, 2012 provider notice, the procedure codes affected by this change are 90853 and 90849. The July 23, 2012 addendum may be viewed at  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120723b.aspx>.

# Prior Approval for Surgeries for Morbid Obesity

- Effective with dates of service on or after October 1, 2012 prior approval is required for surgery for morbid obesity
- For details and instructions regarding submission of prior approval requests please refer to the provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120911a.aspx>
- Prior approval requests must be submitted on Form HFS 1409, Prior Approval Request, along with supporting documentation as explained in the September 11, 2012 provider notice
- The Practitioner Fee Schedule specifies procedure codes requiring prior approval

# 340B Purchased Drugs

- Section 340B of the Public Health Service Act limits the cost of covered outpatient drugs to certain federal grantees, FQHC look-alikes, and qualified hospitals. These providers purchase pharmaceuticals at significantly discounted prices. Such providers enrolled with the US Department of Health and Human Resources Administration are considered 340B providers
- Registration for the program is completed through the Office of Pharmacy Affairs, 1-800-628-6297.
- Providers enrolled with HFS as a provider type other than pharmacy who are submitting fee-for-service claims for 340B purchased drugs must charge HFS no more than their actual acquisition cost for the drug product
- **\$12 Dispensing Fee for 340B Purchased Drugs:**
  - Effective with dates of service on or after February 1, 2013, a \$12.00 dispensing fee add-on applies to generic and brand name drugs purchased through the 340B program. Please refer to the April 15, 2013 provider notice at: <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130415a.aspx>, which instructs providers to identify such drugs by modifying the procedure code with the UD modifier and to include the \$12.00 dispensing fee in the total charges.
  - Reimbursement for 340B purchased drugs will be the lesser of the actual acquisition for the drug, as billed by the provider, or the Department's established 340B allowable reimbursement rate for the drug, plus the applicable dispensing fee.

# Provider Rate Reductions

- Effective with dates of service on or after July 1, 2012, reimbursement rates paid to certain providers were reduced by 2.7%
- Providers exempt from the rate reduction are listed on the fee schedules and include:
  - Physicians
  - Optometrists (medical visits)
  - Dentists
  - APNs
  - Community Mental Health Providers
  - FQHCs, RHCs, and ERCs
  - Local Education Agencies (LEAs)
  - DORs Schools
  - School-based clinics
  - Local Health Departments
  - Hospice agencies
  - Early Intervention
  - Emergency-related transportation
  - Home Health Intermittent Skilled Visits (effective July 1, 2014 as a result of Senate Bill 741)
- The rate reductions will be applied prior to any deductions for co-payments or TPL, including Medicare payments

# 180 Day Time Limit for Claim Submittal

- Claim submittals are subject to a filing deadline of 180 days from the date of service
- *Timely filing applies to both initial and re-submitted claims*
- Claims submitted greater than 180 days but less than 365 days from the date of service will reject G55/"Submitted later than 180 days, but not more than one year, from date of service"
- Claims submitted greater than 365 days from the date of service will reject D05/"Submitted greater than one year from date of service"
- Medicare crossovers (Medicare payable claims) are subject to a filing deadline of two years from the date of service
- Please refer to the Non-Institutional Providers Resources webpage at: <http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx> for links to:
  - The Timely Filing Override Submittal Instructions, which includes a list of exceptions to the timely filing deadline and instructions regarding how to request time override
  - The HFS 1624, Override Request form
  - Timely Filing Override Q & A



# Co-Pays/Cost Sharing

- Co-pay amounts are *not* reflected on the medical cards
- Please refer to the March 29, 2013 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130329a.aspx> and Chapter 100, Appendix 12 for the most up-to-date information about co-payment amounts and applicable eligibility categories
- The Q & A document referenced in the February 14, 2014 provider notice regarding participant liability and co-payments is now available at the Non-Institutional Providers webpage at:  
<http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx>
- When billing the Department *providers should not report the co-payment*, nor deduct it from their usual and customary charge, on the claim. The Department will automatically deduct the co-payment from the provider's reimbursement. This applies to direct billing to HFS – please check with the individual plans for guidance on billing for Medicaid managed care enrollees.

# Co-Pays/Cost Sharing (cont'd)

Participants excluded from cost sharing include:

- Participants with Medicare as primary payer
- Pregnant women, including a 60-day postpartum period. *Either a primary diagnosis of pregnancy in the V22-V39 series or 640-677 series on the claim or current/updated EDD (estimated due date) on the MEDI system are required.*
- All Kids Assist (HFS-covered children under 19 years of age who are not All Kids Share or All Kids Premium)
- Residents of nursing homes, ICFs for the developmentally disabled, and supportive living facilities
- Hospice patients
- All non-institutionalized individuals whose care is subsidized by DCFS or Corrections
- Participants enrolled in HFS MCOs

# Co-Pays/Cost Sharing (cont'd)

Services exempt from cost sharing include:

- Well-child visits
- Immunizations
- Preventive services for children and adults
- Diagnostic services
- Family Planning medical services and contraceptive methods provided
- Services provided under the Breast and Cervical Cancer (BCC) program
- Community Mental Health Services

# Co-pays/Cost Sharing and TPL

- Medicaid is nearly always the payer of last resort
- Participants with other insurance/third party liability and Medicaid secondary may be charged the Medicaid co-payment if accepted as a Medicaid patient, but may not be charged the insurance co-payment
- Example:
  - Adult patient, sick visit, has BC/BS with a \$20 co-payment, and is enrolled in HFS Family Care Assist with a \$3.90 co-payment
  - Provider accepts patient as having Medicaid secondary
  - Provider cannot collect the \$20 BC/BS co-payment, but can collect the HFS \$3.90 co-payment, even if HFS pays \$0.00 because the TPL reimbursement exceeds the state maximum allowed amount

# Cost Sharing for Medicare Advantage Plan Members

- Please refer to the June 19, 2015 provider notice at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150619b.aspx>
- For dates of service July 1, 2015 and after, providers may bill the department for Medicare co-insurance and deductibles for individuals enrolled in a Medicare Advantage Plan and Medicaid
- HFS will consider cost-sharing when the participant is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits
- Providers must submit claims within the twenty-four (24) month timely filing limit for Medicare crossovers
- The Explanation of Benefits should be reviewed to determine if the client has co-insurance and deductibles
- Non-Institutional providers are required to submit a paper HFS 3797, Medicare Crossover or 837P and institutional providers are required to submit a paper UB04 or 837I to the department
- The appropriate three digit TPL code 909 or 910 is required in conjunction with the two digit TPL Status Code

# Fee-For-Service Billing by Hospitals

- Hospitals may submit fee-for-service charges for specific services performed in the hospital outpatient setting at the hospital's main campus or in a hospital-owned off-site clinic within 35 miles of the main hospital campus
- Refer to the Chapter A-200 Practitioner Handbook for Allowable Fee-For-Service Charges by Hospitals for further information and billing guidelines. Please note a reissue of the Chapter A-200 Practitioner Handbook, with revisions to this topic, is forthcoming.
- Evaluation and management services are not billable FFS by hospitals, with the exception of 99211 with modifier TH for the purpose of OB triage when there is no billable APL procedure
- Effective with dates of service on and after July 1, 2016, HFS will allow hospitals to bill the technical component CPT code for and ECG/EKG procedure (tracing only, without interpretation and report). Please refer to the June 30, 2016 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160630b.aspx>.

# Payment for Chemotherapy Services

- In addition to being billable in the outpatient setting by FFS hospitals, chemotherapy administration is billable by physicians and APNs in the office setting
- No payment is made for venous or arterial puncture performed for the purpose of administering chemotherapy
- In addition to the chemotherapy administration, the practitioner may submit charges for the *initial* office visit only. Follow-up visits are included in the chemotherapy administration fee.
- Except for the initial office visit, practitioners may bill for office visits on the same date of service as chemotherapy administration only when done for a separately identifiable condition and billed with modifier 25

# Office Visits

- All E/M CPT codes require a face-to face-encounter with the physician/APN/PA. The only exception is 99211, which may be billed when a recipient comes to the office for a service, such as an injection, and the physician is not required to be present.
- When a therapeutic procedure is performed during an office visit, reimbursement will be made for whichever service the Department prices higher, either the visit or the procedure, but not for both unless it is an initial office visit.
- Diagnostic services are paid separately from a visit based on medical necessity.
- A participant may be designated as a “new patient” only once in a lifetime by an individual practitioner, partner of the practitioner or collectively in a group regardless of the number of practitioners who may eventually see the participant.

# EPSDT Codes

- Well-Child Visits/Preventive Medicine Services are billable according to the periodicity schedule in topic HK-203.1.1 of the Healthy Kids Handbook
  - 99381-99385 new patients
  - 99391-99395 established patients
  
- Developmental Screening
  - 96110
  
- Developmental Assessments
  - 96111
  
- Immunizations (Vaccine billing instructions are located in Chapter 200, Appendix A-9)
  - 90476-90749

# EPSDT Codes (cont'd)

- Lead Screenings
  - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the specimen collection
  - if specimen is not being sent to IDPH and is being analyzed at the office bill 83655
- Hearing Screening
  - 92551
- Vision Screening
  - 99173
- Labs/X-rays
- Mental Health Risk Assessment
  - 99420

Additional information may be found in the Healthy Kids Handbook (HK-200) & Appendices at:

<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/HK200.aspx>

# Adult Preventive Services

- Services rendered for the prevention or diagnosis of a primary disease, or the prevention complication of a chronic disease
- Covered services include preventive evaluation and management office visits, immunizations for participants 21 years and older when administered in accordance with CDC guidelines, screenings for cancer, and diagnostics test and procedures
- One adult preventive medical visit is allowed per year (333 days) in addition to 1 inter-periodic screening visit (e.g. change of PCP)
- Adult Preventive Visits
  - 99385-99387 new patients
  - 99395-99397 established patients
- Immunizations
  - payable when medically necessary and administered according to CDC guidelines
  - example: influenza or pneumococcal

# BMI Assessment & Obesity-Related Weight Management Follow-Up for Children & Adolescents

- Please refer to the January 24, 2014 provider notice for details and billing instructions at:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140124c.aspx>
- Providers are encouraged to follow recommended clinical guidelines for the evaluation & management of overweight and obesity according to the expert committee recommendations linked in the notice
- Primary care physicians and other providers are encouraged to routinely assess and document children's weight status at least one time per year for patients ages 2 through 20
- BMI assessment may be done during any sick or preventive visit. Claims for an episode where BMI is assessed must include the appropriate CPT and diagnosis codes as referenced in the notice
- Providers may bill for weight management visits for children with BMI >85<sup>th</sup> percentile as measured and documented according to the notice. Payable weight management visits may include a maximum of 3 visits within 6 months and may not be billed on the same day as a preventive medicine visit.

# Prenatal/Perinatal Services

## ➤ Prenatal Services

- 0500F (initial prenatal visit) – date of the last menstrual period (LMP) must be reported when billing the initial prenatal CPT
- 0502F (subsequent prenatal visit) – routine urinalysis is not separately reimbursable
- 0503F/59430 (postpartum visit)

## ➤ Perinatal Depression Risk Assessment

- H1000 (screening during a prenatal visit)
- 99420 with HD modifier (screening during a postpartum visit)
- Screening during the infant's visit when the mother is not Medicaid eligible is considered a risk screening for the infant ; bill 99420 with HD modifier using the infant's RIN

## ➤ Additional information is available at:

<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn041130d.aspx>

# Newborn Eligibility

- Any child born to a participant is automatically eligible for medical assistance for one (1) year as long as the mother remains eligible for assistance and the child lives with her
- The mother is not required to submit a formal application for the child to be added to her case
- Medical providers may request that a newborn be added to the Medical Assistance case by contacting the local DHS Family Community Resource Center. Local site locations can be found at: [www.dhs.state.il.us](http://www.dhs.state.il.us)

# Newborn Care



- Newborn care includes the history and examination of the infant, daily hospital visits, initiation of diagnostic and treatment programs, preparation of hospital records including hospital discharge summary
- Charges for *normal* newborn care, when the child's name does not appear on the medical card, may be submitted as follows:
  - Patient Name – enter “Baby Girl” or “Baby Boy”
  - Date of Birth – enter the newborn's birth date
  - Recipient Identification Number – enter the mother's RIN
  - Date of Service – complete the service date box to show the date newborn care was provided
- Billing must be submitted with the child's name and participant number when:
  - The newborn develops complications (i.e. jaundice)
  - The newborn is transferred to NICU
  - A newborn male is circumcised
  - Services are provided after discharge

# Concurrent Care

- When a participant requires the specialized service(s) of an additional practitioner, either concurrently or intermittently during a period of hospitalization, reimbursement may be made for the services of both the attending and consulting practitioner(s) with medical necessity
- Each practitioner must identify the diagnosis he/she is personally treating
- Must be a clear identified practitioner who is responsible for ordering the consultation and approving continuing concurrent care by specialist
- Refer to the Chapter A-200 Practitioner Handbook for information regarding documentation and billing guidelines

# Critical Care

- When a participant receives critical care services in the inpatient, outpatient or ER setting, the practitioner is to bill using the appropriate critical care E/M CPT code
- Payment will be allowed to one practitioner for a maximum of one and one half (1 ½ ) hours of critical care daily for up to ten (10) days per hospital stay for a single participant
- The maximum of ten (10) days of critical care per hospital stay applies whether the service dates are consecutive or intermittent
- Refer to the Chapter A-200 Practitioner Handbook for information and billing guidelines regarding critical care services

# Hospital Care



## ➤ Observation

- Practitioners may charge for hospital observation care by using the appropriate CPT code in accordance with CPT guidelines
- If the participant is admitted to the hospital on the same service date as the observation, a charge may be submitted only for the initial inpatient visit. No payment will be made for observation services.
- Payment will not be made for observation care for consecutive dates of service and only one observation CPT may be billed. The code for observation care “discharge” is not a covered service.
- Payment is not allowed for observational care of obstetrical cases in labor if the participant is admitted to the hospital from concurrent observation and delivers the same day.

## ➤ Inpatient Care

- The admitting practitioner may charge for the initial hospital care of the participant only if not previously provided in the practitioner’s office or on an outpatient basis prior to scheduling the hospital admission
  - Only the admitting practitioner will be paid for the initial hospital visit
  - After the day of admission, the attending practitioner may bill one subsequent hospital visit per day, although payment is not allowed for a visit by the same practitioner who performs/bills a diagnostic or therapeutic procedure on the same date of service
- **Refer to the Chapter A-200 Practitioner Handbook for further information and billing guidelines**

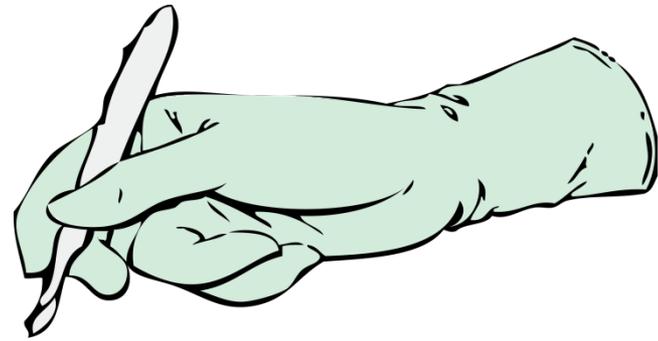
# Consultations

- A consultation is the service rendered by a practitioner at the request of another practitioner, with respect to the diagnosis and/or treatment of a particular illness or condition, with the consultant not assuming direct care of the participant
- The consultation claim must be submitted with the name and NPI of the referring practitioner in the appropriate fields
- A written report from the consulting practitioner to the requesting practitioner is to be included in both the consulting and referring practitioner's medical records
- Refer to the Chapter A-200 Practitioner Handbook for further information and billing guidelines for consultation services

# Anesthesia Services

- Anesthesia services may be provided by the anesthesiologist or the CRNA and should be reported according to the Anesthesia guidelines in the CPT book
- The anesthesiologist or CRNA may bill the Department for services when not paid by the hospital or other entity as an employee or independent contractor
- Anesthesia time must be reported in minutes
- Refer to the Practitioner Handbook Appendices for anesthesia pricing information
- When an office surgical procedure requires the administration of local anesthesia, no additional charge can be made for the anesthesia agent or administration, as both are considered part of the operative procedure
- Refer to the Chapter A-200 Practitioner Handbook for further information and billing guidelines for anesthesia services

# Surgical Services

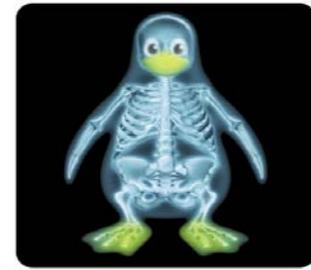


- Payment for a procedure identified on the Practitioner Fee Schedule as major includes postoperative office visits and customary wound dressings for a period of 30 days
- Charges for burn procedures (debridement, grafts, etc.) include postoperative visits, wound care and dressing changes for 7 days after the surgical procedure
- When submitting claims for multiple and/or complex procedures, attach the operative report to the paper HFS 2360. Ensure that the operative report date is the service date indicated on the claim.
- Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package

# Surgical Services (cont'd)

- Procedures considered incidental to, or a component of, the major procedure will not be paid separately
- When more than one operative session is necessary on the same day, operative reports must be submitted with the claim(s) identifying the separate operative times
- Use appropriate modifiers when identifying multiple/bilateral procedures – refer to the Practitioner Fee Schedule Key for instructions for billing multiples
- Use appropriate modifiers when the procedure(s) performed involved digits
- Refer to the Chapter A-200 Practitioner Handbook for further information and billing guidelines regarding surgical services

# Multiple Radiology Procedures



- Multiple radiology procedures on the same day involving areas of the body that are considered overlapping are either paid at a reduced rate or rejected as an x-ray procedure previously paid
- This applies to all services including x-rays, CT/CTAs and MRI/MRAs
- Separate payment will be made for an x-ray and CT of the same area of the body if medically necessary
- Separate payment will be made for CTs and MRIs of completely separate areas of the body
- Refer to the Chapter A-200 Practitioner Handbook for further information and billing guidelines regarding radiology services and overlapping studies

# Therapy Services

- A practitioner may charge only for an *initial* therapy treatment (prior to referral to a licensed therapist) provided in the practitioner's office by the practitioner or the practitioner's salaried staff under the practitioner's direct supervision
- This may be billed in addition to the appropriate evaluation and management CPT code
- Ongoing therapy services are only reimbursed to an enrolled individual therapist
- Individual therapists and hospitals should refer to Chapter J-200, Handbook for Providers of Therapy Services at <http://www.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf> and the therapy fee schedule at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx> for information regarding therapy services

# Provider Fee Schedules

- HFS strives to update the Practitioner Fee Schedule quarterly
- The Practitioner Fee Schedule is posted at:  
<http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/Pages/default.aspx>
- The most recent Practitioner Fee Schedule was posted to the website April 22, 2016 and is effective with dates of service beginning April 1, 2016
- The Practitioner Fee Schedule provides information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization. The fee schedule should be used in conjunction with the fee schedule key, modifier listing, lab panel table, and assistant surgeon rates as applicable.

# Third Party Liability

- Medicaid is nearly always the payer of last resort. All known TPL must be billed before claims may be submitted to HFS. Exceptions include services to women with a diagnosis of pregnancy and preventive services for children.
  - Providers are not required to bill a participant's private insurance carrier for antepartum care services prior to billing the department, however practitioners must bill a participant's private insurance carrier prior to billing the department for *deliveries*
- Client-specific TPL appears on the MEDI eligibility detail screen
- Medicare crossover claims must contain the amount paid by Medicare for each service
- When a client is identified on the HFS system as having TPL, even if the client or TPL source states the TPL is not in effect, the claim must contain complete TPL information, including:
  - TPL resource code - TPL Resource Code Directory appears in Chapter 100, Appendix 9
  - TPL status codes – TPL status codes may be found in the billing instructions for paper claim preparation in the appendices of all Chapter 200 Provider Handbooks
  - Payment amounts
  - TPL date - instructions may be found in the billing instructions for paper claim preparation in the appendices of all Chapter 200 Provider Handbooks

\*\*For discrepancies between TPL reported by participants and TPL information reported in MEDI please contact the TPL unit at 217-524-2490

# HFS Paper Claim Forms

- HFS 2360 – Instructions may be found in Chapter 200, Appendix A-1:
  - Physicians
  - APNs
- HFS 1443 – Instructions may be found in the appendices of each applicable Chapter 200 handbook:
  - Chiropractors
  - Podiatrists
  - Therapists (PT, OT and Speech)
  - Audiologists
  - Optometrists
  - SASS (Children's mental health)
- HFS 3797 – Instructions may be found in Chapter 200, Appendix A-2:
  - All providers billing Medicare crossovers

\*\*Please refer to instructions in the appendices for details regarding required, conditionally required, and optional fields

# HIPAA 5010 Submissions

- The Chapter 300 Companion Guide for 5010 may be viewed at:  
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>
- 5010 submissions sent by a Clearinghouse or uploaded via batch to the MEDI system will receive a 999 Functional Acknowledgement
  - ❖ Please note: A second 999 Functional Acknowledgment is possible as additional audit checks are completed. *A second 999 always indicates rejection of the file(s).*

**\*\*Providers are responsible for verifying that HFS has accepted all submitted files\*\***

# Medical Electronic Data Interchange (MEDI)

➤ MEDI is available for:

- Verifying client eligibility
- Submitting claims
- Submitting replacement claims (bill type '7')
- Submitting voids (bill type '8')
- Downloading the 835 Electronic Remittance Advice
- Checking claim status

**\*\*PLEASE NOTE: HFS BILLING CONSULTANTS DO NOT CHECK CLAIM STATUS\*\***

➤ Login and access requires a State of Illinois Digital Identity

➤ For new users:

- Obtaining a State of Illinois Digital ID is a one-time process
- Requires entry of Illinois-based information from Driver's License/State Identification Card
- Registration must match the provider's information sheet

➤ There are two types of USER registration in the MEDI System:

- Administrator (required - limit of 2)
- Employees (no limit)



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# MEDI (cont'd)

- ANSI 835 (Electronic Remittance Advice) is in Production
- The 835 is available to the designated payee
- HFS error codes are not included on the 835. Codes provided on the 835 are national reason and remark codes which can be found at: <http://www.wpc-edi.com/reference>.
- Providers should refer to the subsequent paper remittance advice for additional information regarding claim rejections

# MEDI (cont'd)

- Once the Illinois Digital Identity registration is complete, login to: <http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx>
  
- For technical assistance with the following please contact 217-524-3814:
  - Authentication error (non-password)
  - Upload batch
  - 835 (ERA) and 999 (FA) assistance
  
- For technical assistance with the following please contact 1-800-366-8768, option 1, option 2:
  - registration
  - digital certificate/password reset
  - administrator/biller authorization

# Voids & Replacement Claims

## ➤ Voids

- May be completed on paper by using the HFS 2292 NIPs Adjustment Form. The Department will no longer stock a paper version for ordering from the warehouse. Providers must use the PDF-fillable format available at the 'Medical Forms Alphabetical Listing' or 'Medical Forms Numeric Listing' link on the Medical Forms page at: <http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx>.
- The instructions for completion of the HFS 2292 may be found in Appendix 6 of the Chapter 100 handbook at: <http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx>
- May be completed electronically by using bill type '8' to void a single service line or entire claim

## ➤ Replacement Claims

- completed electronically by using bill type '7' to void a single service line or entire claim

## ➤ The instructions for electronic voids and replacement claims may be found in the Chapter 300 Companion Guide at:

<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>

- Please Note: voids and replacement claims require the 17-digit DCN from the original, paid claim. Using the 12-digit DCN from the paper remit:
  - Add '201' to the beginning of that 12-digit number
  - Add **either** the 2-digit section number to void or replace a single service line, **or** '00' to void or replace an entire claim, to the end of that 12-digit number

# Referring/Ordering Practitioner

- In the future, referring/ordering and prescribing practitioners will be required to be enrolled with Medicaid
- Providers will be notified via provider notice prior to implementation

# National Correct Coding Initiative (NCCI)

- Medicaid is required to enforce the NCCI edits that Medicare has used for several years
- HFS continues to review updates to these edits as they are published and implement payment policy changes accordingly

# COMMON BILLING ERRORS

- C02 – additional information required
- C03 – illogical quantity
- C17 – place of service illogical
- D01 – duplicate claim – previously paid
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 – client in MCO – Integrated care program
- R36 – client has Medicare – bill Medicare first
- X05 – Hospital visit disallowed
- X06 – surgical package previously paid
- H50 – payee not valid for provider
- M93 – missing payee/multiple payees
- H55 – rendering NPI missing/invalid
- G55 – submitted later than 180 days, but not more than one year, from date of service
- T21 -- Client has Third Party Liability



**Chap. 100 Handbook, Appendix 5 details HFS remittance advice error codes at:**  
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx>

# Contact Numbers for Billing Questions or Prior Approval

**Main Number : 877-782-5565**



## **PLEASE NOTE.....**

- HFS Medical Programs has recently implemented a new phone system and menu options have changed. Additionally, menu options will change again in the near future.
- Claim status is *not* available by phone. Claim status is available using MEDI, the 835 ERA, and the paper remittance advice.



- HFS Home Page <http://www.illinois.gov/hfs/Pages/default.aspx>
- Laws and Rules: <http://www.illinois.gov/hfs/info/legal/Pages/default.aspx>
- Handbooks, including appendices:  
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx>
  - Chapter 100 – General Policy and Procedures
  - Chapter 200 – Provider Handbooks by provider type
  - Chapter 300 – Handbook for Electronic Processing
- Provider Releases and E-Mail Notification for Releases:  
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx>

