



Handbook for Local Education Agencies

Chapter U-200 Policy and Procedures Fee-for-Service Medical Services

**Illinois Department of Healthcare and Family Services
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Chapter U-200 Handbook

Fee-for-Service Policy and Procedures

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Foreword

The Individuals with Disabilities Education Act (IDEA) and Article 14 of the Illinois School Code mandate a free, appropriate public education for all children from 3 through 20 years of age, including children with disabilities. Local education agencies (LEAs) are required to provide, at no cost to parents, special education and related services as delineated in the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). IDEA, as clarified by the Amendments of 1986, includes provisions for other agencies to pay for services.

The Omnibus Budget Reconciliation Act of 1989 allows LEAs to enroll as Medicaid providers and to claim federal reimbursement for certain health services provided to eligible special education students. The Illinois Department of Healthcare and Family Services (hereafter referred to as the department), as the state Medicaid agency, oversees the Fee-for-Service program responsible for the reimbursement of costs incurred by LEAs to provide eligible services.

The department's Chapter U-200 Handbook for Local Education Agencies is specifically designed to familiarize LEAs with the Medicaid claiming and payment system for medical services provided to eligible students. It is not intended to be a complete or comprehensive manual for Medicaid claiming. LEAs should use this guide in conjunction with the department's Chapter 100, Handbook for Providers of Medical Services.

The department's School-Based Health Services Fee-for-Service program is a limited program. This handbook provides information regarding specific policies and procedures which must be followed to receive federal reimbursement.

Acronyms and Definitions

Case documentation – Description of specific service provided including: date, type, length, results/progress, and name, title, and signature of service provider.

Centers for Medicare and Medicaid Services (CMS) – Formerly known as the Health Care Financing Administration (HCFA), the Centers for Medicare and Medicaid Services is the federal agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program (S-CHIP).

Chapter 100 – Department of Healthcare and Family Services policy and procedures handbook for all Medicaid providers.

Chapter U-200 – Department of Healthcare and Family Services policy and procedures handbook, specifically written to assist LEAs with the School-Based Health Services’ Fee-for-Service program.

Cooperative – Voluntary association of school districts that band together to provide special education services using a shared administrative structure.

Department of Healthcare and Family Services (HFS) or (department) – The Department of Healthcare and Family Services (HFS) or (department) is the agency that administers Illinois’ Medical Assistance (Medicaid) Program, as well as other public healthcare programs.

Document Control Number (DCN) – As identified on the HFS 194-M-2 paper Remittance advice, a twelve-digit number assigned by the department to identify each claim that is submitted by a provider. The format is YDDDLLSSSSSS.

Y Last digit of the year claim was received
DDD Julian date claim was received
LL Document Control Line Number
SSSSSS Sequential Number

Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) – Medicaid program for children (until age 21). EPSDT covers any medically necessary service allowable under Medicaid regulations.

Federal Financial Participation (FFP) – The federal money a state receives for expenditures under its Medicaid program. FFP represents a partial reimbursement of a public expenditure.

Fee-for-Service – A payment methodology in which reimbursement is considered for each service provided.

Full-time Equivalent (FTE) – The equivalent number of full-time employees on payroll, computed by dividing the number of hours worked (or used in benefit time) per week by the number of hours in a regular work week. For example: an LEA has a regular work week of 40 hours and employs 3 full-time nurses who each work 40 hours per week and one part-time nurse who works 30 hours per week. The LEA has a headcount of 4 and a FTE of 3.75 (150 hours/40 hours).

[HFS 1443 \(pdf\)](#) – The Department of Healthcare and Family Services Provider Invoice.

Identification Card or Notice – The card issued by the department to each person or family who is eligible under Medical Assistance, as well as other public healthcare programs.

Illinois State Board of Education (ISBE) – The state administrative agency responsible for educational services. Its office relevant to special education is the Department of Special Education.

Individuals with Disabilities Education Act (IDEA) – The federal law that mandates that a free and appropriate public education be available to all school-age children with disabilities. It is also known as Public Law 105-17.

Individualized Education Program (IEP) – A written plan for every student receiving special education services that contains information such as the student’s special learning needs and the specific special education services required for the student. The document is periodically reviewed and revised.

Individualized Family Service Plan (IFSP) – The IFSP is a written plan for infants and toddlers with disabilities that describes services to be provided and expected outcomes, and is developed in cooperation with the child’s parents or guardian.

Joint agreement – Also called a “cooperative.” A joint agreement is a voluntary association of school districts who join together to provide special education services.

Local education agency (LEA) – A public elementary or secondary school, unit school district, special education cooperative, or joint agreement.

Medicaid – A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act. It covers children, the aged, blind, disabled, and people who are eligible to receive federally assisted income maintenance payments.

Medical Programs – The Medical Assistance Program authorized under Title XIX of the Social Security Act and the State Children’s Health Insurance Program authorized under Title XXI of the Social Security Act.

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

Occupational therapy – A service that emphasizes remediation of or compensation for perceptual, sensory, visual-motor, fine-motor, and self-care deficits.

Office of the Inspector General – The Illinois General assembly created the Office of the Inspector General (OIG) within the Department of Public Aid in 1994. The OIG is mandated to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in the programs administered by the Illinois Department of Healthcare and Family Services and the Illinois Department of Human Services.

Payee 1 – Entity designated by a Medicaid provider to receive its Fee-for-Service payments.

Physical therapy – A service that emphasizes remediation of or compensation for mobility, gait, muscle strength, and postural deficits.

Procedure Code – The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

Provider – Entity enrolled to supply Medicaid services to eligible populations.

Provider Participation Unit – The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

Recipient Eligibility Verification (REV) system – Public Act 88-554 mandated that the Department of Healthcare and Family Services create a statewide electronic Recipient Eligibility Verification (REV) system. The REV system is available to enrolled providers throughout the state. The REV system utilizes various clearinghouses that relay electronic transactions back and forth between a provider and the department. These clearinghouses, known as REV vendors, have direct telecommunication line access into department databases. Each REV Vendor has developed a unique process of transmitting data to the providers. REV Vendors develop standardized software for providers to use on existing personal computers, point-of-service devices, and provide programming for existing computer systems to accept and transmit data.

Recipient Identification Number (RIN) – The nine-digit identification number unique to the individual receiving coverage under one of the department's Medical Programs. It is vital that this number is correctly entered on billings for services rendered.

Remittance advice – A document issued by the department which reports the status of claims (invoices) and adjustments processed. It may also be referred to as a voucher.

School-Based Health Services (SBHS) – Medicaid-funded program that provides reimbursement for eligible costs incurred by LEAs to provide medical services related to a child’s Individualized Education Program (IEP). Services include audiology services, developmental assessments, hearing screening, medical equipment, medical services, medical supplies, nursing services, occupational therapy, physical therapy, psychological services, school health aide, social work services, speech/language services, transportation, and vision screening. Some program administrative costs are also reimbursed.

Skilled Professional Medical Personnel (SPMP) – Personnel who have completed a two-year or longer professional educational program leading to an academic degree or certification in a medical or medically-related profession, who have skilled professional medical activities included in their job descriptions, and who use their professional medical knowledge in performing work-related activities.

Special education – Specially designed instruction, provided at no cost to the parent, to meet the unique needs of a child with disabilities, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

State Medicaid agency – The organization in each state directly responsible for the administration of the Medicaid program. Each state must designate a “single state agency” for purposes of accountability to CMS, even though a number of state (and local) agencies may help the program or function as medical providers. The Department of Healthcare and Family Services is the designated single state agency for Illinois.

State Plan – Document between the states and Federal government which details the scope of the Medicaid program in the state listing the services offered, any applicable requirements and limitations, and the payment rate for those services. The State Plan consists of preprinted material that covers the basic requirements and individualized content that reflects the characteristics of the particular state Medicaid program. The State Plan is submitted by the state and subject to approval from CMS.

Title XIX of the Social Security Act – Title XIX of the Social Security Act provides for federal grants to the states for medical assistance programs. Originally enacted by the Social Security Amendments of 1965 and Public Law 89-97, Title XIX was approved July 30, 1965. Title XIX is popularly known as Medicaid, and is administered by the Centers for Medicare and Medicaid Services.

Title XXI of the Social Security Act – Title XXI of the Social Security Act created the State Children’s Health Insurance Program (S-CHIP). The purpose of the law is to assist states in initiating and expanding children’s health assistance programs to uninsured, low-income children.

Chapter U-200

Local Education Agency Services

U-200 Basic Provisions

For consideration to be given by the department to claims submitted by a LEA, services must be provided by an LEA enrolled for participation in the department's Medical Programs. LEA services must be provided in full compliance with the general provisions in Chapter 100, Handbook for Providers of Medical Services and the policies and procedures outlined in Chapter U-200.

Chapter 100, Chapter U-200, and several other state and federal handbooks and guides can be viewed and downloaded from [HFS' School-Based Health Services \(SBHS\) website](#).

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the department's Medical Programs policy and billing procedures. Periodic updates to the handbook will be released as operating experience and state or federal regulations require policy and procedure changes in the department's Medical Programs. The updates will be posted to the SBHS Web site.

U-201 Provider Participation

U-201.1 Participation Requirements

Providers qualified to enroll in the Fee-for-Service program include:

- School districts with an enrolled student population
- Special education cooperatives and joint agreements
- Schools administered by the Illinois Department of Human Services - Office of Rehabilitation Services

Special education cooperatives and joint agreements may file claims on behalf of the LEA served by the special education cooperative or joint agreement using the provider NPI assigned to the entity that incurred the cost for which the cooperative/joint agreement is claiming.

Each LEA is required to enroll as a provider in the department's Medical Programs and to sign a provider agreement with the department.

Procedure: The LEA must complete and submit:

- Form HFS 2243 pdf (Provider Enrollment/Application)
- Form HFS 1413 pdf (Agreement for Participation)
- W9 (Request for Taxpayer Identification Number)
- Form HFS 1513 pdf (Enrollment Disclosure Statement)

In addition, if the LEA wishes to make claims for administrative costs, the following must be completed and submitted.

- Intergovernmental Agreement - Administrative Claiming (2 copies)
- Form DPA 2243-A (Payee Information Form)

The Intergovernmental Agreement and the DPA 2243-A may **only** be obtained from the Provider Participation Unit (PPU) by calling (217) 782-0538. All other forms listed above may be obtained by visiting the [HFS General Provider Enrollment Requirements webpage](#).

The original copy of each form must be completed (printed in black ink or typewritten), signed by the authorized agent of the LEA and returned to Illinois Department of Healthcare and Family Services, Provider Participation Unit, Post Office Box 19114, Springfield, Illinois, 62794-9114. A copy of each completed form should be retained by the LEA.

U-201.2 Participation Approval

When participation is approved, the department will provide the LEA with a computer-generated notification, the Provider Information Sheet, listing all data on the department's computer files. The LEA will be enrolled as a Provider Type 47, with the exception of the Department of Human Services - Office of Rehabilitative Services schools which will be Provider Type 53. The LEA must review the Provider Information Sheet for accuracy immediately upon receipt.

Refer to Appendix U-3 for an explanation of the entries on the Provider Information Sheet.

If all information is correct, the LEA must retain the Provider Information Sheet for subsequent use in completing billing statements to ensure that all identifying information is an exact match to that in the department's file.

U-201.3 Participation Denial

When participation is denied, the LEA will receive written notification of the reason for denial. An LEA denied participation may request a review of that decision.

Within ten days after such notice, the LEA 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 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 defined in 89 Ill. Admin. Code 140.14. Department rules concerning the administrative hearing process are defined in 89 Ill. Admin. Code 104 Subpart C.

U-201.4 Provider File Maintenance

The information contained in department files for participating LEAs must be maintained on a current basis. The LEA and the department share responsibility for keeping the file updated.

LEA Responsibility - The Provider Information Sheet must be reviewed for accuracy immediately upon receipt. If all information is correct, the LEA should retain the Provider Information Sheet for subsequent use in completing billing invoices, to insure that all identifying information required is an exact match to that in the department's files.

The LEA is required to notify the department of any subsequent changes in the data contained on the Provider Information Sheet. Each time the LEA receives an updated Provider Information Sheet, it must be reviewed for accuracy.

Any inaccuracies found must be corrected and the department notified immediately.

Procedures:

Option 1: To correct information on the Provider Information Sheet, line out the incorrect information, write the correct information, date, and sign an original signature on the line provided.

Option 2: On the LEA letterhead, list the following information:

- LEA name and address as it is currently printed on the Provider Information Sheet
- Corrected or updated information, such as; LEA name and address, phone number or payee information
- Provider Number
- FEIN Number
- Effective date of the change
- Signature

The corrected Provider Information Sheet or the letter may be mailed or faxed to the Provider Participation Unit at:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
FAX (217) 557-8182

Department Responsibility - Whenever there is a change in an LEA's enrollment status or any change is submitted by the LEA, an updated Provider Information Sheet will be generated reflecting the change and effective date and mailed to the LEA and to each payee listed on the LEA's provider file.

U-202 Local Education Agency’s Expenditures

U-202.1 Expenditures

Expenditures must be submitted to the department only after services have been provided. Expenditures must be the actual costs of providing the services. If services are provided to more than one student, group rates must be used, where available. For example:

- Transportation Services - To determine a round-trip cost per child, the reported Special Education transportation costs must be divided by the number of special education students in the LEA for the year, divided by the number of School Attendance Days.
- Group Therapy - The claimable cost of the therapy session must be multiplied by the department’s group differential factor.

Reimbursement made by the department for allowable services provided will be based on the federally approved cost calculation methodology for LEAs.

U-202.2 Electronic Claims Submittal

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in [Chapter 100, Topic 112.3](#) or [Chapter 300, 5010 Companion Guide](#).

LEAs should take special note of the requirement that Form 194-M-C, Billing Certification Form, which the provider will receive with the remittance advice, must be signed and retained by the LEA for a period of three years from the date on the voucher. Failure to do so may result in revocation of the LEA’s right to bill electronically, recovery of monies, or other adverse actions. Refer to [Chapter 100, Topic 130.5](#) for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Follow the instructions for the medium being used. If a problem occurs with electronic billing, the LEA should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for the LEA to contact its software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data.

U-202.3 Claims Preparation and Submittal

Chapter 100, Topics 112.4, 112.41, 112.42 and 112.43 provide general policy and procedure for the preparation and mailing of paper claims.

Form HFS 1443, Provider Invoice must be used to submit expenditures for all services provided by the LEA. For detailed instructions on completion of the HFS 1443 and a copy of the claim form, refer to appendix U-1.

Routine claims must be submitted in the - HFS 1444, Provider Invoice Envelope, the pre-addressed mailing envelope provided by the department. Use of the pre-addressed envelope should insure that claims arrive in their original condition and that they are properly routed for processing.

The department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix U-1 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scan function or imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of HFS
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

In some instances, a second type of pre-addressed envelope, the HFS 2248, Special Approval Envelope, must be used for mailing claims. This envelope must be used when submitting a non-routine claim. A non-routine claim is:

- A claim to which Form 1411, Temporary Medical Eligibility Card, is attached
- A claim to which any other document is attached

To order the department forms and envelopes mentioned above refer to Chapter 100, General Appendix 10 or visit the [HFS Medical Forms Request web page](#).

U-202.4 Federal Reimbursement

Reimbursement by the department is limited to the federal financial participation for eligible expenditures incurred by the LEA. Reimbursement will be made at the regular Federal Medical Assistance Percentage. Claiming for services provided by federally funded personnel is not permitted.

Reimbursement will be issued to the LEA's designated payee once a month. Remittance advices associated with the reimbursement's non-rejected claims will be issued to the designated payee once a month. Remittance advices associated with the reimbursement's rejected claims will be issued to the designated payee weekly.

The remittance advices will provide the detail for each claim submitted by the LEA, such as reimbursement and error codes for each service rejected. The LEA is to

review the remittance advices to determine if the reimbursement is correct and submit an adjustment for incorrect reimbursements. If the service has been rejected, for other than **H37**, “**Services Not Covered for LEA/DORS**”, the claim must be reviewed, corrected and resubmitted to receive reimbursement. The **H37 error** code message will be shown for those students for whom federal reimbursement cannot be collected. Each of these subjects is discussed in detail in Chapter 100, in the following areas:

- Remittance Advice, refer to Chapter 100, General Appendix 8
- Error Codes listing, refer to Chapter 100, General Appendix 5
- Adjustments, refer to Chapter 100, General Appendix 6

U-202.5 Timely Filing

The department must submit expenditures for federal matching funds within 24 months from the date of the expenditure. Because the department submits expenditures for federal matching funds on a quarterly basis, the department requires that claims be submitted expeditiously, but no later than 18 months from the date of service. This procedure helps ensure adequate time to claim the federal reimbursement. For example, for a service rendered July 1, 2013, the department must receive the claim by January 1, 2015.

U-203 Covered Services

Covered services are face-to-face health related services provided to a student, group of students, or parent/guardian on behalf of the student. Covered services are listed in Illinois' State Plan and are medically necessary for the development of the IEP/IFSP or fully documented in the IEP/IFSP. Covered services are:

- Audiology Services
- Developmental Assessments
- Hearing Screening
- Medical Equipment
- Medical Services
- Medical Supplies
- Nursing Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- School Health Aide
- Social Work Services
- Speech/Language Services
- Transportation
 - Medicar
 - Private Automobile
 - Service Car
 - Taxicab Services
 - Transportation - Other
- Vision Screening

When submitting claims for reimbursement the LEA must use the appropriate Current Procedural Terminology (CPT) code(s). These codes are listed in Appendix U-2.

U-204 Non-Covered Services

Services listed below are not covered by the Fee-for-Service program and will not be approved for reimbursement.

- Medical care not related to the IEP/IFSP or the development of the IEP/IFSP such as illness and injury care, health education classes, first aid classes, and chemical abuse classes
- Art, music, or recreation therapy including adaptive physical education, unless these activities are part of physical therapy services
- Services provided by parents, foster parents, or adult siblings
- Transportation of students who do not require a special adaptation or aide
- Transportation of students on days when another covered medical service is not provided
- Classroom instruction or educational services
- Services provided by terminated, suspended, or barred practitioners
- Services not listed in Appendix U-2

U-205 Record Requirements

LEAs must maintain records which fully document the basis upon which all claims for reimbursement payments are made. A complete set of records includes the student's medical record, case documentation, billing records, and practitioner credentials. All documentation must be available, if requested, for state and federal audits. Chapter 100, Handbook for Providers of Medical Services, Topic 134, contains information regarding the department's audit process.

LEAs must retain all service and financial records, supporting documents, and other recipient records relating to the delivery of service for a period of five (5) years after payment of federal funds. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the five (5) year period, the records must be retained until completion of the action and resolution of all issues arising from it.

U-205.1 Student Eligibility Verification

To be eligible for covered services students must:

- Be under 21 years of age
- Require services necessary for the development of an IEP/IFSP or have an IEP/IFSP in place that includes the covered services
- Be enrolled in a federally funded Medicaid Program
- Be eligible for a federally funded Medicaid Program on the date services are provided
- Receive a covered service on the date(s) claimed for reimbursement

To verify a student's Medicaid eligibility use one of the following methods:

- Ask to see the student's medical eligibility card.
- Use the department's Recipient Eligibility Verification (REV) system. To access the REV system, LEAs need to obtain the services of a REV vendor. A current list of REV vendors is available on the [Recipient Eligibility Verification \(REV\) Program website](#).
- Use the department's Automated Voice Response System (AVRS) to verify Medicaid eligibility. By calling 1-800-842-1461, an LEA can use their provider number, the student's recipient identification number, and a date of service to verify eligibility.
- Look up eligibility using the Medical Electronic Data Interchange (MEDI) System. [Medi Eligibility Lookup](#)
- Contact the local Department of Human Services (DHS) office. See [Provider Handbook Chapter 100](#) Appendix 1

U-205.2 Student Medical Record

A student's medical record must include:

- Results of tests or evaluations performed for the development of an IEP/IFSP, if an IEP/IFSP is not already developed
- A complete copy of the IEP/IFSP that includes frequency, duration, and scope of services provided
- Copies of any amendments to the IEP/IFSP
- Medical diagnosis and/or condition
- Case documentation including a complete description of the specific service provided including: date, type, length, service description, and name, title, and written or electronic signature of service provider as detailed in Section U-205.3

All entries to the student's medical record must be dated, legible, and written in English. Records that cannot be audited because of illegibility are not proper records.

The department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, LEAs should be aware that medical records are key documents for post payment audits.

In the absence of proper and complete records, federal reimbursement payments may be recouped.

U-205.3 Case Documentation

LEAs must document all services for which Medicaid reimbursement is claimed. This documentation must be maintained for each student by each service practitioner. Each occurrence of an IEP/IFSP service must be documented and the documentation must be kept in the student's medical record.

The IEP/IFSP is not sufficient documentation of actual services provided for reimbursement claiming.

LEAs may use any documentation format or combination of formats (such as case notes and service logs) that includes all of the information listed below or copy and use the activity log in Appendix U-4.

- Student's name
- Student's date of birth
- School
- Service date
- Service description

- Duration of face-to-face service (time spent)
- Service type (OT, PT, SLP, etc.)
- Medical diagnosis or prescription as required by service type (Section U-210)
- Service practitioner's name, title, and written or electronic signature
- Signature of service practitioner's supervisor, if required

In addition to the service-specific documentation requirements listed above, LEAs must maintain documentation of the student's response and progress resulting from the claimed service. This documentation must be updated no less than quarterly.

U-205.4 Billing Records

Billing records must include:

- The Provider Information Sheet (Section U-201.2 and Appendix U-3)
- An original signed billing certification form for every voucher paid
- Cost information including: salaries, benefits, employment hours, and face-to-face service hours
- Transportation services trip logs that record all required elements listed in Section U-210.13

U-205.5 Practitioner Credential Records

The LEA must verify that no practitioner providing service has been terminated, suspended, or barred from the Medicaid or the Medicare program. The lists of terminated, suspended, and barred practitioners can be found on the [HFS Office of the Inspector General Provider Sanctions web page](#) or the [U.S. Department of Health and Human Services Office of the Inspector General Searchable Exclusions Database web page](#). Both lists must be queried to obtain a complete list of terminated, suspended, or barred providers.

Both of these sites can be accessed from the [SBHS website](#).

A completed copy of the Verification Statement in Appendix U-5, may be retained in the practitioner credential record as verification that the practitioner is not terminated, suspended, or barred from the Medicaid or Medicare program. The verification statement should be updated annually.

The LEA is responsible for maintaining credential records in line with staff qualifications outlined in Section U-210 and applicable law.

Practitioner credential records must:

- Be retained in hardcopy or electronic format by the LEA
- Be current
- Include copies of all applicable licenses and certificates
- Include a list of current practitioners and associated license numbers

U-210 General Limitations and Considerations on Covered Medical Diagnostic and Treatment Services

Covered services are face-to-face, health-related services provided to a student, group of students, or parent/guardian on behalf of the student. Consultations (excluding IEP/IFSP meetings) must include the student or parent/guardian on behalf of the student to be claimable. Covered services are listed in Illinois' State Medicaid Plan and are medically necessary for the development of the IEP/IFSP or fully documented in the IEP/IFSP.

Covered services are subject to Medicaid requirements for coverage of services, including prior authorization. The prior authorization requirement is met by including the frequency, duration, scope, and medical necessity of each covered service in the IEP/IFSP.

Covered services claimed, but not fully documented, are subject to recoupment of the reimbursement paid. Refer to Section U-205 for record requirements.

Reimbursement by the department is limited to the federal financial participation for eligible expenditures incurred by the LEA. Reimbursement will be made at the regular Federal Medical Assistance Percentage. Claiming for services provided by federally funded personnel is not permitted.

U-210.1 Audiology Services

Service Description

Audiology services necessary for the development of the student's IEP/IFSP or documented in the IEP/IFSP include, but are not limited to:

- Evaluations, tests, tasks, and interviews to identify hearing loss in a student whose auditory sensitivity and acuity are so deficient as to interfere with normal functioning
- Auditory training and speech reading
- Counseling and guidance regarding hearing loss
- Determining the need for group and individual amplification
- Providing for selection and fitting of hearing aids
- Evaluating the effectiveness of amplification

Professional Qualifications

Master's degree in audiology and licensure by the Illinois Department of Financial and Professional Regulation or Master's degree in audiology and Certificate of Clinical Competence in audiology.

Refer to Appendix U-2 for the appropriate procedure codes to use for submitting claims.

U-210.2 Developmental Assessments

Service Description

Determining a student's level of needed service by utilizing recognized assessment tools including, but not limited to:

- Vision assessments - students may be assessed once a year at age appropriate intervals unless additional screenings are medically necessary.
- Hearing assessments – children may be assessed at age appropriate intervals. After the initial screening, all children may be assessed once a year unless additional screenings are medically necessary.
- Developmental assessments may be given at age appropriate intervals.

Professional Qualifications

Non-physician personnel administering vision, hearing, or developmental assessments to preschool and school age children should be appropriately trained to provide the assessment. Certification by the Illinois Department of Public Health for vision and hearing assessments should be completed, if possible.

Refer to Appendix U-2 for the appropriate procedure code(s) to use for submitting claims.

U-210.3 Medical Equipment

Service Description

Medical equipment, as specified in the student's IEP/IFSP, is durable equipment, such as wheelchairs, canes, walkers, etc. The equipment is for the exclusive use of the student and is the property of the student.

Claimable Services

Medically necessary equipment may be claimed up to a total of \$1000 per day. Equipment costing more than \$1000 must be obtained through a durable medical equipment provider enrolled with the department.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.4 Medical Services

Services Description

Medical services necessary for the development of the student's IEP/IFSP, performed for the purpose of identifying or determining the nature and extent of the student's medical or other health-related condition.

Professional Qualifications

State of Illinois licensed physician

Refer to Appendix U-2 for the appropriate procedure code to use for submitting claims.

U-210.5 Medical Supplies

Service Description

Medical supplies, as specified in the student's IEP/IFSP, are medical items purchased for use at school which are not durable or reusable, such as surgical dressings, disposable syringes, catheters, urinary trays, etc.

Claimable Services

Medically necessary supplies may be claimed up to \$500 per day. Supplies exceeding \$500 per day must be procured through a durable medical equipment provider enrolled with the department.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.6 Nursing Services

Service Description

Nursing services, necessary for the development of the student's IEP/IFSP or documented in the IEP/IFSP, are professional services relevant to the medical and rehabilitative needs, provided through direct service intervention or consultation.

Nursing services include, but are not limited to:

- Administering and monitoring medication
- Catheterization
- Evaluations and assessments
- Tube feeding
- Suctioning
- Monitoring a student's health condition
- Providing information and recommendations regarding the student's condition and plan of care

Professional Qualifications

Registered Nurse (RN), licensed by the Illinois Department of Financial and Professional Regulation; or

School nurse (LSN) with a Type 73 Certificate or current ISBE equivalent endorsed in school nursing; or

Licensed Practical Nurse (LPN), licensed under the Illinois Nursing Act, working under the direction of a RN or LSN.

“Under the direction of” is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed, and who is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners working under his or her direction.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.7 Occupational Therapy**Service Description**

Occupational therapy services necessary for the development of the student’s IEP/IFSP or documented in the IEP/IFSP include, but are not limited to:

- Evaluation of problems which interfere with the student’s functional performance
- Implementation of a therapy program of purposeful activities which are rehabilitative, active, or restorative as prescribed by a licensed physician. These activities are designed to:
 - improve, develop or restore functions impaired or lost through illness, injury or deprivation
 - improve ability to perform tasks for independent functioning when functioning is impaired or lost
 - prevent, through early intervention, initial or further impairment or loss of function
 - correct or compensate for a medical problem interfering with age appropriate functional performance

A physician’s order is required for occupational therapy services. The physician’s order must be updated annually and be maintained in the student’s health record.

Occupational therapy services may be provided in either an individual or group setting. The number of participants in the group session should be limited to assure effective delivery of service.

Professional Qualifications

Occupational therapist, registered by the American Occupational Therapy Association and licensed by the Illinois Department of Financial and Professional Regulation; or

Certified occupational therapist assistant, practicing under the direction of a licensed occupational therapist.

“Under the direction of” is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed and who is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners under his or her direction.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.8 Physical Therapy**Service Description**

Physical therapy services necessary for the development of the student’s IEP/IFSP or documented in the IEP/IFSP include, but are not limited to:

- Evaluations and diagnostic services
- Therapy services which are rehabilitative, active or restorative. These services are designed to correct or compensate for a medical problem and are directed toward the prevention or minimization of a disability, and may include:
 - developing, improving, or restoring motor function
 - controlling postural deviations
 - providing gait training and using assistive devices for physical mobility and dexterity
 - maintaining maximal performance within a student’s capabilities through the use of therapeutic exercises and procedures

Physical therapy services are required to be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under law. The prescription must be updated annually and be maintained in the student’s health record.

Physical therapy may be provided in either an individual or group setting. The number of participants in the group session should be limited to assure effective delivery of service.

Professional Qualifications

Physical therapist, licensed by the Illinois Department of Financial and Professional Regulation; or

Certified physical therapist assistant practicing under the direction of a licensed physical therapist .

“Under the direction of” is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly reviews (at least monthly) the work performed and who is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners under his or her direction.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.9 Psychological Services**Service Description**

Psychological services necessary for the development of the student’s IEP/IFSP or documented in the student’s IEP/IFSP are diagnostic or active treatments with the intent to reasonably improve the student’s physical or mental condition and are provided to the student whose condition or functioning can be expected to improve with interventions. These services include, but are not limited to:

- Testing and evaluation that appraise cognitive, emotional, and social functioning, and self-concept
- Interviews and behavioral evaluations including interpretations of information about the student’s behavior and conditions relating to functioning
- Therapy, including providing a program of psychological services for the student with diagnosed psychological problems
- Unscheduled activities for the purpose of resolving an immediate crisis situation

Psychological services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications

Psychologists with a Type 73 Certificate or current ISBE equivalent endorsed in school psychology; or

Psychologists licensed by the Illinois Department of Financial and Professional Regulation; or

Psychologist intern with ISBE approval, who provides services under the direction of a qualified school psychologist.

“Under the direction of” is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed, and is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners under his or her direction.

Refer to Appendix U-2 for the appropriate CPT code(s) to use for submitting claims.

U-210.10 School Health Aide

Service Description

School health aide services, documented in the student’s IEP/IFSP, provide assistance with activities of daily living and are necessitated by the student’s medical condition. These services include, but are not limited to:

- Transferring and ambulating
- Assistance with food, nutrition, and diet activities
- Bowel and bladder care
- Redirection and intervention for medically-related behavior (non-discipline related)

These services are generally the responsibility of family members when the student is at home.

Professional Qualifications

School health aide services are provided by staff who have been trained and remain under the direction of skilled professional medical personnel or a qualified professional. Services provided to the student by family members are not claimable. (Exception: In the instance of a student who receives services through a home and community-based waiver and continuity of care is determined to be in the best interest of the student, the student’s provider under the waiver program may continue to provide the personal care services in the school setting.)

“Under the direction of” is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed, and is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners under his or her direction.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.11 Social Work Services

Service Description

Social work services necessary for the development of the student's IEP/IFSP or documented in the student's IEP/IFSP are diagnostic or active treatments provided with the intent to reasonably improve the student's physical or mental condition or functioning. Social work services include those services provided to assist the student or family members in understanding the nature of the disability, the special needs of the student, and the student's development. These services include, but are not limited to:

- Screenings, assessments, and evaluations
- Social development studies
- Counseling and therapy
- Unscheduled activities for the purpose of resolving an immediate crisis situation

Social work services may be provided in an individual, group, or family setting. The number of participants in the group session should be limited to assure effective delivery of service.

Professional Qualifications

Social worker with a Type 73 certificate or current ISBE equivalent, endorsed in school social work; or

Licensed social worker possessing at least a Master's degree in social work and licensed by the Illinois Department of Financial and Professional Regulation, in accordance with the Clinical Social Work and Social Work Practice Act; or

Social work intern with ISBE approval who provides counseling and evaluation services under the direction of a qualified social worker as defined above.

"Under the direction of" is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed, and who is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners under his or her direction.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

U-210.12 Speech/Language Services

Service Description

Speech/Language therapy services necessary for the development of the student's IEP/IFSP or documented in the student's IEP/IFSP include, but are not limited to:

- Diagnostic services
- Screening and assessment
- Preventative services
- Corrective Services

A referral by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under law is required for speech/language services. The referral must be updated annually and be maintained in the student's health record.

Speech/Language services may be provided in either an individual or group setting. The number of participants in the group session should be limited to assure effective delivery of services

Professional Qualifications

Type 03, Type 09, Type 10 Teaching or Type 73 School Services Personnel Certificate* endorsed in Speech/Language Pathology and a Certificate of Clinical Competence; or

Type 03, Type 09, Type 10 Teaching or Type 73 School Services Personnel Certificate* endorsed in Speech/Language Pathology with the equivalent educational requirements and work experience necessary for the Certificate of Clinical Competence; or

Type 03, Type 09, Type 10 Teaching or Type 73 School Services Personnel Certificate* endorsed in Speech/Language Pathology, licensed by the Illinois Department of Financial and Professional Regulation, in accordance with the Illinois Speech/Language Pathology and Audiology Practice Act; or

Type 03, Type 09, Type 10 Teaching or Type 73 School Services Personnel Certificate* endorsed in Speech/Language Pathology with completed academic requirements, in the process of acquiring supervised work experience to qualify for licensure in accordance with the Illinois Speech/Language Pathology and Audiology Practice Act; or

Speech Language Pathologist, licensed by the Illinois Department of Financial and Professional Regulation, in accordance with the Illinois Speech/Language Pathology and Audiology Practice Act; or

Speech/Language paraprofessional, assistant, aide or intern practicing under the supervision of a qualified speech/language pathologist.

“Under the direction of” is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed, and who is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners under his or her direction.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

*Or current ISBE equivalent certification qualification.

U-210.13 Transportation Services

Medicaid funding is reserved for transportation services to and from school for children on days when they receive a medical service in school and specialized transportation needs are specifically identified in their IEP/IFSP. In addition, if a child with special health care needs requires specialized transportation to and from school for a medical service but lives in an area that does not have routine school bus service (e.g., close proximity to the school), transportation may be billed to Medicaid. Specialized transportation from the school to a provider in the community is also a claimable service.

The transportation costs for a child with special education needs, as identified in the IDEA, who rides the regular school bus to his or her neighborhood school with non-disabled children should not be billed to Medicaid.

Transportation Services Documentation

LEAs must maintain records which fully document the basis upon which all claims for reimbursement payments are made, including claims for transportation services.

LEAs may choose any paper or electronic documentation format that includes all of the information listed below.

- Student’s name
- Student’s recipient identification number
- School name
- Service date
- Procedure code (see Appendix U-2)
- Vehicle identifier (license plate number or bus number)
- Name of attendant/aide, if applicable
- Verification that an eligible student utilized the transportation service for each trip claimed for reimbursement

Documentation must also be kept that indicates the student received another covered service on the date(s) special transportation services are billed.

Medicar

Service Description

As documented in the IEP/IFSP, medicar services are provided to a student whose medical condition requires the use of a hydraulic or electric lift or ramp and wheelchair lock downs, or transportation by stretcher when the medical need does not require attendance by an emergency medical technician, medical equipment, the administration of drugs or oxygen, etc.

Qualified Staff

Medicar Company vendor licensed by the Illinois Secretary of State.

Claimable Services

One or more round trips to a source of medical care not to exceed 100 miles per day.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

Taxicab Services

Service Description

As documented in the student's IEP/IFSP, taxicab services are transportation services provided by passenger vehicle to a student whose medical condition does not require a specialized mode of transportation.

Qualified Staff

Taxicab vendor licensed by the Illinois Secretary of State.

Claimable Services

One or more one way or round trips to a source of medical care not to exceed 50 miles per day.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

Service Car

Service Description

As documented in the IEP/IFSP, service car services are transportation services provided by passenger vehicle to a student whose medical condition does not require a specialized transportation mode.

Qualifications

"Livery" classification license from the Illinois Secretary of State.

Claimable Services

One or more one way or round trips to a source of medical care not to exceed 100 miles per day.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

Private Automobile Transportation

Service Description

As documented in the student's IEP/IFSP, private automobile transportation services are transportation services provided by a passenger vehicle to a student whose medical condition does not require a specialized transportation mode.

Qualified Staff

Non-employee of the school, licensed by the Illinois Secretary of State.

Claimable Services

One or more one way or round trips to a source of medical care not to exceed 100 miles per day.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

Other Transportation - (adapted buses, lift vehicles, vans)

Service Description

As documented in the student's IEP/IFSP, other transportation services are those services provided to transport the student to and from the student's place of residence and the location where health-related services are provided, as well as from school to the site of medical or therapy services and back. The student's specific needs must require special accommodation for transport in order to receive the LEA health-related services.

Provider Qualifications

Entities licensed by the Illinois Secretary of State and, where appropriate, by local regulating agencies.

Enrolled LEA-based health services provider or contracted vendor of transportation.

Claimable Services

One or more round trips to a source of medical care on a day the student receives another covered service.

Refer to Appendix U-2 for the appropriate procedure code(s) for submitting claims.

Transportation services may include, but are not limited to, transport in specialized vehicles such as adapted buses, lift vehicles, vans and transportation where assistance is provided on a vehicle or where special needs must be taken into consideration because of a student's health condition.

U-210.14 Diagnosis Codes

All claims require a primary diagnosis code as listed in the International Classification of Disease, Ninth Edition, Clinical Modification (ICD-current version-CM), or upon implementation, ICD-10.

The new revision of the ICD-CM is available approximately September 15th of each year. The primary diagnosis reflects the condition primarily responsible for the student's treatment.

The ICD-CM is available from the publisher at:

Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, California 90010
1-800-633-7467

The ICD-CM, may also be available at your local bookstore or from Internet book sellers.

Appendix U-1
Technical Guidelines for Paper Claim Preparation
Form HFS 1443, Provider Invoice

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the department:

- Use original department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable.

Completion	Item	Explanations and Instructions
Required	1.	Provider Name- Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	2.	Provider Number- Enter the provider's NPI.
Required	3.	Payee- Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. 1=Local Education Agency (as payee) Always enter 1
Not Required	4.	Role- Leave blank.
Not Required	5.	Emer- Leave blank.
Not Required	6.	Prior Approval- Leave blank.
Optional	7.	Provider Street- Enter the street address of the provider's primary office. If the address is entered, the department will, where possible, correct claims suspended due to provider errors. If address is not entered, the department will not attempt corrections.
Conditionally Required	8.	Facility & City Where Service Rendered- This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office) or 12 (home).
Optional	9.	Provider City State ZIP- Enter city, state and ZIP code of provider.
Not Required	10.	Referring Practitioner Name– Leave blank.
Required	11.	Recipient Name– Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required	12.	Recipient Number- Enter the nine-digit number assigned to the individual as shown on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use no punctuation or spaces. Do not use the Case Identification Number.
Optional	13.	Birth Date– Enter the month, day and year of birth of the patient as shown on the Medical Programs card. Use the MMDDYYYY format. If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name or number errors. If the birth date is not entered, the department will not attempt corrections.

Completion	Item	Explanations and Instructions
Not Required	14.	H Kids- Leave blank.
Not Required	15.	Fam Plan- Leave blank.
Not Required	16.	St/Ab- Leave blank.
Required	17.	Primary Diagnosis Description- Enter the primary diagnosis that describes the condition primarily responsible to the patient's treatment.
Required	18.	Primary Diag. Code- Enter the specific ICD-9-CM code, without the decimal, for the primary diagnosis described in Item 17.
Required	19.	Taxonomy- Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.
Optional	20.	Provider Reference- Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form 194-M-1, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. - Leave blank.
Optional	22.	Secondary Diag Code- A secondary diagnosis code may be entered when applicable.
	23.	Service Sections- Complete one Service Section for each item or service provided to the patient.
Required		Procedure Description/Drug Name, Form, and Strength or Size- Enter the description of the service provided.
Required		Proc. Code/NDC- Enter the appropriate CPT, HCPCS or NDC.
Conditionally Required		Modifiers- Enter the appropriate two-byte modifier (s) for the service performed. The department can accept a maximum of 4 two-byte modifiers per Service Section.
Required		Date of Service- Enter the date the service was provided. Use MMDDYY format.
Required		Cat. Serv.- Enter the appropriate two-digit category of service code. Refer to Appendix U-2.
Conditionally Required		Delete- When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only the "X" will be recognized as a valid character; all others will be ignored.
Required		Place of Serv.- Enter the two-digit Place of Service code from the following list: 03- School 11- Office 12- Home
Conditionally Required		Units/Quantity- Refer to Appendix U-2 for appropriate units to bill for service provided.
Not Required		Modifying Units- Leave blank
Not Required		TPL Code- Leave blank
Not Required		Status – Leave blank
Not Required		TPL Amount – Leave blank
Not Required		TPL Date – Leave blank
Required		Provider Charge- Enter the total charge for the service.
Not Required	24.	Optical Materials Only- Leave blank.

Completion	Item	Explanations and Instructions
Not Required	25A.	TPL Code – Leave blank.
Not Required	25B.	Status- Leave blank.
Not Required	25C.	TPL Amount – Leave blank.
Not Required	25D.	TPL Date- Leave blank.
Not Required	26.	Sect. #- Leave blank.
Not Required	26A.	TPL Code- Leave blank.
Not Required	26B.	Status- Leave blank.
Not Required	26C.	TPL Amount- Leave blank.
Not Required	26D.	TPL Date- Leave blank.
Not Required	27.	Sect. Leave blank.
Not Required	27A.	TPL Code- Leave blank.
Not Required	27B.	Status- Leave blank.
Not Required	27C.	TPL Amount- Leave blank.
Not Required	27D.	TPL Date- Leave blank.
Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.		
Required	28.	Tot Charge- Enter the sum of all charges submitted on the Provider invoice in Service Sections 1 through 6.
Required	29.	Tot Deductions- Enter the sum of all payments submitted in the TPL Amount field in the Service Sections 1 through 6. If no payment was received, enter zeroes (0 00). Do not deduct department co-payments.
Required	30.	Net Charge- Enter the difference between Total Charge and Total Deductions.
Required	31.	# Sects- Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections that were deleted because of errors.
Not Required	32.	Original DCN- Leave blank.
Not Required	33.	Sect. – Leave blank.
Not Required	34.	Bill Type- Leave blank.
Not Required	35.	Uncoded TPL Name- Leave blank.
Required	36-37	Provider Certification, Signature and Date- After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format.

MAILING INSTRUCTIONS

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the department. The copy of the claim should be retained by the provider.

Routine claims are to be mailed to the department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the department.

Mailing address: Healthcare and Family Services
 P.O. Box 19105
 Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or split bill transmittals (HFS 2432) are to be mailed to the department in a pre-addressed mailing envelope, Form HFS 2248, NIPS Special Invoice Handling Envelope, which is provided by the department for this purpose.

Mailing address: Healthcare and Family Services
 P.O. Box 19118
 Springfield, Illinois 62794-9118

Forms Requisition:

Billing forms may be requested on our [website](#) or by submitting an [HFS 1517](#) as explained in Chapter 100, General Appendix 10.

Appendix U-2

Procedure Codes Billable by Local Education Agencies

Audiology Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category Of Service
V5299	Audiology	14

Developmental Assessments- Billed with a unit of 1 for each assessment with a maximum billable quantity of 1 unit each for 99173 and 92551, a maximum billable quantity of 8 units for 96110, and a maximum billable quantity of 7 units for 96111		
Procedure Code	Description	Category Of Service
99173	Vision screen	30
92551	Hearing screen	30
96110	Ages & Stages Questionnaires (ASQ)	30
96110	Ages & Stages Questionnaires Social Emotional (ASQ:SE)	30
96110	Battelle Developmental Screener	30
96110	Bayley Infant Neurodevelopment Screener	30
96110	Brief Infant Toddler Social and Emotional Assessment (BITSEA)	30
96110	Brigance Early Preschool	30
96110	Chicago Early Developmental	30
96110	Screening Inventory	30
96110	Denver DST/Denver II	30
96110	Developmental Profile II	30
96110	Dial-R Developmental Assessment	30
96110	Dial - 3	30
96110	Early Language Milestone Scales Screen	30
96110	Early Screening Inventory	30
96110	Early Screening Profiles	30
96110	Infant-Toddler Symptom Checklist	30
96110	Minneapolis Preschool Screening Instrument	30
96110	Modified Checklist for Autism in Toddlers M-CHAT	30
96110	Parents' Evaluation of Developmental Status (PEDS)	30
96110	Parents' Evaluation of Developmental Status -- Developmental Milestones (PEDS: DM)	30
96110	Parents' Observations of Infants and Toddlers (POINT)	30
96110	Project Memphis DST	30
96110	Revised Developmental Screening Inventory	30
96110	Revised Parent Developmental Questionnaire	30
96110	Temperament and Atypical Behavior Scale (TABs) Screener	30
96111	Battelle Developmental Inventory	30
96111	Bayley Scales of Infant Development	30

Procedure Code	Description	Category Of Service
96111	Child Behavior Checklist 2-3 and Caregiver-Teacher Report Form, Ages 2-5	30
96111	Child Development Inventory	30
96111	Conner’s Rating Scales	30
96111	Early Coping Inventory	30
96111	Erhardt Development Prehension Assessment	30
96111	Hawaii Early Learning Profile	30
96111	Infant-Toddler Developmental Assessment	30
96111	Infant-Toddler Social and Emotional Assessment (ITSEA)	30
96111	McCarthy Screening Test	30
96111	Otis-Lenon School Ability Test	30
96111	Piers-Harris Children’s Self Concept Scale	30
96111	Temperament and Atypical Behavior Scale (TABS) Assessment Tool	30
96111	Vineland Adaptive Behavior Scales	30
96111	Vineland Mal Adaptive Skill	30
96111	Vineland Social-Emotional Early Childhood Scales	30
96111	Vineland Social Maturity Scale	30

Medical Equipment - Billed with a unit of 1		
Procedure Code	Description	Category of Service
A9900	Equipment	41
Medically necessary equipment may be claimed up to a total of \$1,000 per day. Equipment costing more than \$1,000 must be obtained through a Medicaid enrolled durable medical equipment (DME) provider.		

Medical Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
T1018	Medical Services	01

Medical Supplies - Billed with a unit of 1		
Procedure Code	Description	Category of Service
99070	Medical Supplies	48
Medically necessary supplies may be claimed up to a total of \$500 per day. Supplies exceeding more than \$500 per day must be procured through a Medicaid enrolled durable medical equipment and supplies (DME) provider.		

Medication Administration - Billed in units of 5 minute increments with Modifier KO with a maximum billable quantity of 3 units		
Procedure Code	Description	Category of Service
T1502	RN, LPN, Certified School Nurses	10
Registered Nurses (RN), licensed practical nurses (LPN) working under the supervision of RNs, and certified school nurses may use this code when dispensing medication to eligible students.		

Nursing Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
T1002	RN Services	10
T1003	LPN Services	10

Occupational Therapy - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
97535	Individual Occupational Therapy	12
97799	Group Occupational Therapy	12

Physical Therapy - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
97110	Individual Physical Therapy	11
97150	Group Physical Therapy	11

Psychological Services - Billed in units of 15 minute increments with Modifier AH with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
90810 obsolete 12/31/12	Individual Psychological Service	59
90832 effective 1/1/13	Individual Psychological Service	59
90853	Group Psychological Service	59

School Health Aide (SHA) - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
T1021	School Health Aide	93

Social Work Services - Billed in units of 15 minute increments with Modifier AJ with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
96152	Individual Social Work	58
96153	Group Social Work	58

Speech/Language Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
92507	Individual Speech Therapy	13
92508	Group Speech Therapy	13

Transportation - Billed with a unit of 1		
Procedure Code	Description	Category of Service
A0130	Medicar	52
A0120	Private Automobile	55
T2004	Service Car	54
One or more one way or round trips to source of medical care not to exceed 100 miles per day.		

Taxicab Services - Billed with a unit of 1		
Procedure Code	Description	Category of Service
A0100	Taxicab	53
One or more one way or round trips to source of medical care not to exceed 50 miles per day.		

Other Transportation - Billed with a unit of 1		
Procedure Code	Description	Category of Service
T2003	Transportation	56
One or more round trips to source of medical care per day when another Medicaid/SCHIP service is provided.		

Note: Seven minutes of face-to-face service must be provided in order to claim one unit. 1 unit equals 15 minutes. When the service time is greater than one unit 7 minutes, enter 2 units. When the service time is less than one unit 7 minutes, round down to the lesser unit, enter one unit.

Appendix U-3 Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date the signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic U 201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet.

Field	Explanation
Provider Key	This number uniquely identifies the provider, and is used internally by the department. It is linked to the reported NPI(s).
Provider Name And Location	This area contains the Name and Address of the provider as carried in the department's records. The three-digit County code identifies the county where the provider is located. The Telephone Number is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information reflecting the manner in which the provider is enrolled with the department. Provider Type is a three-digit code and corresponding narrative that indicates the provider's classification.

Field	Explanation
	<p>Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:</p> <ul style="list-style-type: none"> 01 = Sole Proprietary 02 = Partnership 03 = Corporation <p>Enrollment Status is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the department’s Medical Programs. Cost report requirements are also indicated. The possible codes are:</p> <ul style="list-style-type: none"> B = Active, Cost Report Not Required I = Inactive N = Non Participating <p>Immediately following the enrollment status indicator are the Begin date indicating when the provider was most recently enrolled in the department’s Medical Programs and the End date indicating the end of the provider’s most current enrollment period. If the provider is still actively enrolled, the word “ACTIVE” will appear in the End date field.</p> <p>Exception Indicator may contain a one-digit code and corresponding narrative indicating that the provider’s claims will be reviewed manually prior to payment. The possible codes are:</p> <ul style="list-style-type: none"> A = Intent to Terminate B = Expired License C = Citation to Discover Assets D = Delinquent Child Support E = Provider Review F = Fraud Investigations G = Garnishment I = Indictment L = Student Loan Suspensions R = Intent to Terminate/Recovery S = Exception Requested by Provider Participation Unit T = Tax Levy X = Tax Suspensions <p>If this item is blank, the provider has no exception. Immediately following the Exception Indicator are the Begin date indicating the first date when the provider’s claims are to be manually reviewed and the End date indicating the last date the provider’s claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.</p>

Field	Explanation
Categories of Service	<p>This area identifies the types of service a provider is enrolled to provide.</p> <p>Eligibility Category of Service contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. Each entry is followed by the date on which the provider was approved to render services for each category listed. The <u>Provider Enrollment Application (HFS 2243)</u> defines all applicable categories of services.</p>
Payee Information	<p>This area records the name and address of the entity authorized to receive payments on behalf of the provider. The payee is assigned a single-digit Payee Code.</p>
	<p>Payee ID Number is a sixteen-digit identification number assigned to each payee, for whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.</p>
NPI	<p>The National Provider Identification Number contained in the department's database.</p>
Signature	<p>The provider is required to affix an original signature when submitting changes to the Department of Healthcare and Family Services.</p>

Appendix U-3a Reduced Facsimile of Provider Information Sheet

MEDICAID SYSTEM (MMIS) PROVIDER SUBSYSTEM REPORT ID: A2741KD1 SEQUENCE: PROVIDER TYPE PROVIDER NAME	STATE OF ILLINOIS HEALTHCARE AND FAMILY SERVICES PROVIDER INFORMATION SHEET	RUN DATE: 10/16/13 RUN TIME: 11:47:06 MAINT DATE: 10/16/13 PAGE: 84
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--PROVIDER KEY-- <div style="border: 1px solid black; padding: 2px; display: inline-block;">000011111111</div>	PROVIDER NAME AND ADDRESS	<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">PROVIDER TYPE:</td> <td colspan="3">047 - LOCAL EDUCATION AGENCY</td> </tr> <tr> <td>ORGANIZATION TYPE:</td> <td colspan="3">03 - CORPORATION</td> </tr> <tr> <td>ENROLLMENT STATUS</td> <td>B - ACTIV NO CST</td> <td>BEGIN 09/05/13</td> <td>END ACTIVE</td> </tr> <tr> <td>EXCEPTION INDICATOR</td> <td>- NO EXCEPT</td> <td>BEGIN</td> <td>END</td> </tr> </table>	PROVIDER TYPE:	047 - LOCAL EDUCATION AGENCY			ORGANIZATION TYPE:	03 - CORPORATION			ENROLLMENT STATUS	B - ACTIV NO CST	BEGIN 09/05/13	END ACTIVE	EXCEPTION INDICATOR	- NO EXCEPT	BEGIN	END
PROVIDER TYPE:	047 - LOCAL EDUCATION AGENCY																	
ORGANIZATION TYPE:	03 - CORPORATION																	
ENROLLMENT STATUS	B - ACTIV NO CST	BEGIN 09/05/13	END ACTIVE															
EXCEPTION INDICATOR	- NO EXCEPT	BEGIN	END															

RE-ENRL IND: N	DATE:	CERTIFIC/LICENSE NUM -	ENDING
INSTUTION INFORMATION:		CLIA #:	
INSTITUTION BED CNT:	INST BED: BEGIN	LAST TRANSACTION ADD	AS OF 10/16/13 MEDICARE #

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	TERMINATION REASON

CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1								

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
XXXXXXXXXX

***** PLEASE NOTE: *****

* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE

X

Appendix U-4

HFS
School-Based Health Services
IEP/IFSP Services Activity Log

Student Name:

Type of Service Provided

(As listed in Appendix U-2 in Chapter U-200):

Date of Birth:

School/LEA: _____

Date of Service MM/DD/YY	Time Spent	Number of Children in Group	Service Description Results, response, case notes; must relate to IEP/IFSP goals/objectives

Signature _____

Date _____
Service Provider/Practitioner

Typed/Printed Name _____

Appendix U-5

A completed copy of the Verification Statement may be retained in the practitioner credential record as verification that the practitioner is not terminated, suspended, or barred from the Medicaid or Medicare program.

Verification Statement

(Name): _____,

Practitioner at (Name of LEA): _____,

has been verified as not being terminated, suspended, or barred from the Medicaid or

Medicare program. Electronic look ups can be obtained at the [OIG Sanction List](#) and at [HHS Sanction list](#).

This verification was performed by (Name): _____

Date of verification: _____