Illinois Department of Healthcare and Family Services

Physician Billing Webinar

September 10, 2015

What's New at HFS?

- New Website Resources for NIPS Providers
- Family Planning Policy Change and Payment Increases
- Fee-For-Service Billing of Synagis (RSV Recombinant)
- ACA PCP Enhanced Payments Ended
- Provider Reimbursement
- Hospital Billing and Reimbursement for Immediate Postpartum Long-Acting Reversible Contraceptives
- Payment of Cost Sharing for Medicare Advantage Plan (MAP) Members
- Illinois Medicaid Program Advanced Cloud Technology (IMPACT)
- ICD-10-CM Implementation

New Provider Website Resources

- The following links were added to the department website; providers are encouraged to review these sites before contacting a billing consultant.
  - **Claims Processing System Issues, added 09-19-14**
    http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx: provides the most current system issues the department is experiencing, as well as information regarding resolutions
  - **Non-Institutional Providers Resources, added 09-19-14**
    http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx: provides answers to frequently asked questions regarding participant co-pays and liability, a list of exceptions to the timely filing deadline, timely filing override request instructions and request form, and links to webinar slides
  - **Illinois Medicaid Program Advanced Cloud Technology (IMPACT), added 04-14-15**
    http://www.illinois.gov/hfs/impact/Pages/default.aspx: provides information regarding the new Medicaid Management Information System project, including on-line provider enrollment and re-validation options.

Family Planning Policy Change and Payment Increases

- **The provider notice dated November 10, 2014 at** http://www.hfs.illinois.gov/assets/111014n1.pdf **outlines the family planning policy changes effective for dates of service beginning 10-01-14**
- **Increased reimbursement rate for insertion/removal procedures of Long Acting Reversible Contraceptives (LARCs)**
  - Refer to the notice for specific CPT codes in addition to previous rates and new rates
- **Evaluation/Management (E/M) visit on the same day as LARC insertion or removal**
  - is separately reimbursable when contraceptive options are discussed during an initial or annual preventative visit or a postpartum visit, the device is placed, and the E/M code is submitted with modifier 25
  - is separately reimbursable when contraceptives are discussed during a problem focused visit initiated for reasons other than LARC insertion, the device is placed on the same date of service, and the E/M code is submitted with modifier 25
  - is not separately reimbursable when a previously chosen LARC method is reviewed and followed by placement of the LARC
- **The appropriate diagnosis code from the V25.xx series in the ICD-9-CM or the appropriate ICD-10-CM (upon implementation) must be used for the primary code attached to the insertion (and/or removal) procedure code**

Family Planning Policy Change and Payment Increases (cont'd)

- **Vasectomy reimbursement rate increase**
  - Refer to the notice for specific CPT code and new rate
- **Increase in medical dispensing fee add-on for certain 340B birth control methods and change in allowable coding for emergency contraceptive pills**
  - Effective July 1, 2014 the dispensing fee for family planning methods purchased through the 340B federal Drug Pricing Program 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

Family Planning Policy Change and Payment Increases (cont'd)

- **Effective July 1, 2014 the department will no longer reimburse emergency contraceptive pills (ECPs) billed with procedure code J8499**
  - All ECPs must be billed using procedure code S4993 effective July 1, 2014
  - Providers who billed EC with procedure code J8499 for dates of service on or after July 1, 2014 should submit replacement claims using procedure code S4993
  - HFS has updated the dispensing policy of emergency contraception allowing for advance provision of up to three (3) doses if clinically indicated

- **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

Fee-For-Service Billing of Synagis

- Effective November 1, 2014, hospitals may no longer bill fee-for-service for Synagis. Only enrolled pharmacies are allowed to submit claims in accordance with the Synagis criteria through the pharmacy point-of-sale system. http://www.hfs.illinois.gov/assets/092314n.pdf

Provider Reimbursement

- **Affordable Care Act Primary Care Provider enhanced payments ended with dates of service after 12-31-14, as posted at** http://www.hfs.illinois.gov/assets/120314n1.pdf
  - HFS continues to finalize adjustments to 2013-2014 services

- **16.75% rate reduction for dates of service between May 1 – June 30, 2015**
  - http://www.hfs.illinois.gov/assets/050115n3reimbursementrate.pdf
  - This rate reduction has expired ; however, the 2.7% rate reduction for certain providers continues, as mandated with the SMART Act effective July 1, 2012

- **State Fiscal Year 2016 Budget Information**
  - http://www.hfs.illinois.gov/assets/071015n.pdf
  - HFS is processing service-related claims; providers who have follow up questions regarding payment are advised to monitor the vendor payments portal on the IOC website

Hospital Billing and Reimbursement for Immediate Postpartum LARCs

- Effective with dates of service on and after July 1, 2015, HFS will allow hospitals separate reimbursement 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 Informational Notice at http://www.hfs.illinois.gov/assets/063015n.pdf
- 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

Cost Sharing for Medicare Advantage Plan Members

- The June 19, 2015 Informational Notice concerning the new HFS policy can be found at http://www.hfs.illinois.gov/assets/061915n1.pdf
- 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 with 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

IMPACT
Illinois Medicaid Program Advanced Cloud Technology

- **IMPACT is a multi-agency effort to replace Illinois' legacy Medicaid Management Information System (MMIS) with a web-based system to give providers a more convenient and consistent user experience, and to ensure clients receive timely and high-quality Medicaid services**

- **IMPACT Home Page:** http://www.illinois.gov/hfs/impact/Pages/default.aspx

- **Provider notices addressing IMPACT:**
  - Introduction of IMPACT: http://www.hfs.illinois.gov/assets/041415n.pdf
  - Notice of suspension of paper/implementation of Phase I: http://www.hfs.illinois.gov/assets/050815n.pdf
  - Enrollment of Billing Agents: http://www.hfs.illinois.gov/assets/061615n.pdf
  - Provider educational sessions: http://www.illinois.gov/hfs/impact/Pages/ProviderOutreach.aspx
  - Requirements for enrolling: http://www.hfs.illinois.gov/assets/062415n1.pdf

IMPACT
Illinois Medicaid Program Advanced Cloud Technology

- On August 3, 2015, Illinois began enrolling and revalidating all Medicaid-funded providers and billing agents through the new web portal at http://www.illinois.gov/hfs/impact/Pages/Login.aspx
- Paper enrollment applications or updates are no longer accepted
- While billing/claiming processes will remain unchanged in 2015 and 2016, failure to enroll or revalidate on time can lead to payment delays
- When logging in to begin the enrollment/revalidation process, make sure to have:
  - a National Provider Identifier (NPI) Number
  - a certified W9 on file
  - renewed any professional certifications or licensures
  - the appropriate web access (an email address and an Internet browser equivalent to Internet Explorer 8 – or a more recent browser ; specifically for IMPACT, Chrome and Firefox seem to cause less functionality issues)
  - your Application ID Number – all currently enrolled providers were previously sent an application ID number in order to access their application in IMPACT. If this ID number is lost or misplaced, contact the IMPACT help desk at IMPACT.Help@Illinois.gov

ICD - 10

- **The conversion from ICD-9-CM code set to ICD-10-CM code set, as federally mandated, is effective October 1, 2015. Please refer to the June 17, 2015 Informational Notice (including FAQs) at** http://www.hfs.illinois.gov/assets/061715n1.pdf
  - ICD-10-CM diagnosis codes will not be accepted on electronic or paper claims for dates of service prior to October 1, 2015
  - ICD-9-CM diagnosis codes will not be accepted on electronic and paper claims for service dates on or after October 1, 2015
  - HFS will reject claims submitted with both ICD-9-CM and ICD-10-CM diagnosis codes on the same claim

- **The department has revised the following paper claim forms to accommodate ICD-10-CM diagnosis coding; the revision date at bottom left corner of the form is R-2-15:**
  - HFS 2210 – DME equipment and supplies
  - HFS 2211 – Laboratory/Portable X-ray
  - HFS 2212 – Health Agency

- **The revised forms may be ordered from the Medical Forms Request page at** http://www2.illinois.gov/hfs/MedicalProvider/Forms%20Request/Pages/default.aspx
  - Either the current version or the revised version of the HFS 2210, HFS 2211, and HFS2212 can be used to submit claims for dates of service prior to October 1, 2015
  - For dates of service on or after October 1, 2015, paper HFS 2210, HFS 2211, and HFS 2212 claim forms must be submitted on the form with revision date **R-2-15**

Senate Bill 741
Medicaid Benefit Changes

- Details may be found on the HFS website at http://www2.illinois.gov/hfs/agency/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
- Mandated prior approval for speech, occupational and physical therapies for children through age 20, which is forthcoming. The effective date of this change will be announced via Informational Notice to providers. Currently, therapy prior approval is required only for participants age 21 and older.

Update to Adult Dental Coverage

- Please refer to the June 26, 2014 Informational notice at: http://www.hfs.illinois.gov/assets/062714n.pdf
- 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 Services

- **Effective with dates of service on and after January 1, 2014 the department will reimburse providers for tobacco cessation counseling and pharmacotherapy services rendered to pregnant and post-partum women ages 21 and over, as well as to children through age 20, as outlined in the provider notice dated August 26, 2014 posted at** http://www.hfs.illinois.gov/assets/082614n.pdf

- **Tobacco cessation counseling for the above populations....**
  - may be a separately billable service under either of 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
  - 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
  - have the following limitations 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
  - have no maximum number of counseling sessions for children through age 20

Tobacco Cessation Services (cont'd)

- **Pharmacotherapy (nicotine replacement therapy)**
- **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 at http://ilpriorauth.com/ for specific drug coverage and prior approval requirements
  - 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
- **Tobacco Quitline:**
  - Illinois Tobacco Quitline website at http://quityes.org/
  - Toll-free call 1-866-QUIT-YES (1-866-784-8937)

Reminder: Annual Medical Cards

- Please refer to the provider notice dated January 30, 2013 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, Recipient 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.myhfs.illinois.gov/

    *****when using MEDI be sure to scroll down in order to view possible MCO enrollment***
  - The REV system. A list of vendors is available at: http://www2.illinois.gov/hfs/MedicalProvider/rev/Pages/default.aspx
  - The Automated Voice Response System (AVRS) at 1-800-842-1461

Home Health Care Services

- **Face-To-Face Requirement**
  - As a result of the SMART Act effective with dates of service on or after 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.hfs.illinois.gov/assets/121113n.pdf 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 review the October 2, 2014 Informational Notice at http://www.hfs.illinois.gov/assets/100214n.pdf

Four Prescription Policy

- As a result of the SMART Act, 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.hfs.illinois.gov/pharmacy/script/

- 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.hfs.illinois.gov/assets/090412n1.pdf

- Effective with the December 10, 2013 provider notice at http://www.hfs.illinois.gov/assets/121013n.pdf, 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

- As a result of the SMART Act 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 will no longer be 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
- As a result of the Affordable Care Act effective January 1, 2014 a patient's primary insurance may cover the costs formerly covered through the State Hemophilia Program. In accordance with Public Act 98-0104, patients must meet their obligations under ACA 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 participants by letter regarding these changes.** Please refer to the December 27, 2013 provider notice at http://www.hfs.illinois.gov/assets/122713n.pdf for more information and a provider contact number.

Sexual Assault Emergency Treatment Program

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS will reimburse 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 release at: http://www.hfs.illinois.gov/assets/062912n2.pdf
- 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

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, some services will no longer be 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.hfs.illinois.gov/assets/062712n3.pdf
- 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, as identified on a claim by applying the GW modifier to the procedure code

Chiropractic Services

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS has 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.hfs.illinois.gov/assets/063012n.pdf
- 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.hfs.illinois.gov/assets/070112chiro.pdf

Prior Approval for Surgeries for Morbid Obesity

- As a result of the SMART Act effective with dates of service on or after October 1, 2012 prior approval is required for surgery for morbid obesity
- The prior approval requirement includes assistant surgeons
- For details and instructions regarding submission of prior approval requests please refer to the provider notice at: http://www.hfs.illinois.gov/assets/091112n.pdf
- 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

Provider Rate Reductions

- **As a result of the SMART Act effective with dates of service on or after July 1, 2012, reimbursement rates paid to certain providers were reduced by 2.7%**
- **For details please refer to the provider notice at** http://www.hfs.illinois.gov/assets/071712n1.pdf
- **Providers exempt from the rate reduction 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

- As a result of the SMART Act claims received with dates of service on or after July 1, 2012 are subject to a filing deadline of 180 days from the date of service

- The Non-Institutional Providers Resources website at http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx now offers Timely Filing Override Submittal Instructions in addition to a link to the HFS 1624, Override Request form and a link to FAQs

- ***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. Claims submitted greater than 365 days from the date of service will reject D05.

- Medicare crossovers (Medicare payable claims) are subject to a filing deadline of two years from the date of service. Claims may be submitted electronically or on the paper HFS 3797 at the following address:

  HFS
  P.O. Box 19109
  Springfield, IL 62794

180 Day Time Limit for Claim Submittal (cont'd)

- Claims addressed to a HFS post office box are received M-F between 8:30 am and 5:00 pm at a distribution center for further sorting and delivery to specified locations

- Upon arrival at the Bureau of Claims Processing, paper claims are assigned a document control number (DCN) within 24 hours. The first 7 numbers of the DCN represent the Julian date the claim was received. If the claim must be routed to a different bureau for special handling, the paper claim will be physically date stamped on the day received in that bureau

- Timeliness of override requests received in the Bureau of Professional and Ancillary Services, when allowed based on exceptions to the timely filing limit as explained in the following slides, is determined by the date stamped on the claim upon receipt in the bureau

Exceptions to the 180 Day Time Limit

Written requests for timely filing overrides for any of the exceptions in the following slides, and as stated in the July 23, 2012 provider notice, require a manual override (unless otherwise noted) and must be submitted with an original and correct claim form and any attachments as indicated in the following slides to:

HFS – Bureau of Professional and Ancillary Services (BPAS)
Attn: Practitioner Billing Consultant
P.O. Box 19115
Springfield, IL 62794-9115

***Timely filing will be the only edit authorized for bypass. Should there be rejections due to billing errors unrelated to timely filing, those claims will not be allowed another time override**

Exceptions to the 180 Day Time Limit

- Medicare denied claims – up to 2 years from the date of service. Attach to a paper claim form HFS 2360, HFS 1443, HFS 2210, or HFS 2211: the EOMB showing HIPAA-compliant denial reason/remark codes and cover letter stating the reason for request for timely filing override.
- New provider enrollment, provider reenrollment or addition of a new category of service or addition of an alternate payee - 180 days from the date the enrollment or update was entered on the provider file by the Provider Participation Unit (PPU). Attach to a paper claim: the HFS 1624 Override Request Form stating the reason for the override
- Retroactive recipient eligibility – up to 180 days from the system update, which may be viewed on MEDI at www.myhfs.illinois.gov when verifying eligibility. Attach to a paper claim: the HFS 1624 Override Request Form stating the reason for the override.
- TPL – up to 180 days from final adjudication by the primary payer. ***These claims may now be billed electronically. TPL information must be reported.***
- Primary TPL recoupment – up to 180 days from the date of the recoupment notification. Attach to a paper claim: a copy of the recoupment notification and the HFS 1624 Override Request Form stating the reason for the override

Exceptions to 180 Day Time Limit (cont'd)

- Split bill – up to 180 days from the date on the HFS 2432 Split Billing Transmittal/Spenddown Form. Attach to a paper claim: the HFS 2432 and the HFS 1624 Override Request Form stating the reason for the override. TPL fields must be completed.
- Replacement claims (one electronic transaction) – must be completed within 12 months from original paid voucher date to be considered timely
- Void & Re-bill (two separate transactions) – considered timely if the void transaction is completed within 12 months from original paid voucher date and the re-billed claim is received within 90 days of the void DCN. If manual override is required for the re-billed claim, attach to a paper claim: the HFS 1624 Override Request Form stating the reason for the override
- Errors attributable to the department or any of its claims processing intermediaries that result in an inability to receive, process or adjudicate a claim – the180 day period shall not begin until the provider has been notified of the error via:
  - Date on the paper voucher/remittance advice….or….
  - Fix date on the Claims Processing Systems Webpage at http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx

Co-Pays/Cost Sharing

- Co-pay amounts will *not* be reflected on the annual medical cards
- The provider notice dated March 29, 2013 and attached updated Appendix 12 at http://www.hfs.illinois.gov/assets/032913n.pdf provides 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 new Non-Institutional Providers Resources link at http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/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.
- The department is in the process of issuing adjustments for some co-payments incorrectly taken. Please refer to the August 20, 2014 provider notice at http://www.hfs.illinois.gov/assets/082014n.pdf for details.

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

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
- 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
- Refer to Chapter 200, Topic 202.13 Allowable Fee-For-Service Charges by Hospitals for further information and billing guidelines
- Effective with dates of service on and after July 1, 2015, HFS will allow hospitals separate reimbursement for Long–acting reversible contraceptives (LARCs) provided immediately postpartum in the inpatient hospital setting (please refer to the Family Planning slide #8)

Fee-For-Service Billing by Hospitals (cont'd)

Services billable FFS by hospitals:

- Administration of chemotherapy agents for the treatment of cancer
- Administration and supply of the following injectible medications:
  - Chemotherapy agents for the treatment of cancer
  - Non-chemotherapy drugs administered for conditions associated with the chemotherapy and submitted with the cancer-related diagnosis
  - Baclofen
  - Lupron
  - RhoGAM
  - Tysabri

  **PLEASE NOTE: although previously billable, Synagis is no longer reimbursed FFS to hospitals effective April 1, 2014 per policy stated in the June 2, 2005 provider notice. Please refer to the September 23, 2014 Informational Notice at http://www.hfs.illinois.gov/assets/092314n.pdf
- Reference (outside) laboratory services
- Outpatient laboratory and radiology services ordered by a physician
- Durable Medical Equipment and Supplies
- Speech and Occupational Therapy
- Telehealth
- E/M service 99211 with modifier TH for the purpose of OB triage, ONLY when there is no billable APL procedure. *****No other E/M services are billable FFS by hospitals.***

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 NCCI and 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

- EPSDT services are billable according to the guidelines published in the Chapter HK-200 Healthy Kids Handbook at http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/HK200.aspx
- Well-child/Preventive visits should follow the posted periodicity schedule in Section 203.1 for:
  - 99381 - 99385 new patient
  - 99391 - 99395 established patient
- Developmental Screening: 96110
- Developmental Assessments: 96111
- Immunizations: 90476 – 90749
- Lead Screenings:
  - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the IDPH test kit preparation
  - if specimen is analyzed at the office bill 83655
- Hearing Screening: 92251
- Vision Screening: 99173
- Labs/X-rays
- Mental Health Risk Assessment: 99420

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

- Please refer to the January 24, 2014 provider notice at http://www.hfs.illinois.gov/assets/012414n2.pdf for details and billing instructions
- 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 >85th 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.

Adult Preventive Services

- 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
- Screening for cancer

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.hfs.illinois.gov/assets/112904pd.pdf

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.

- **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 one attending/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 Chapter 200, Topics A-220.4 and A-220.5 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 Chapter 200, Topic A-220.6 Consultations for further information 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
- Refer to Chapter 200, Topic A-220.8 Critical Care Services for further information and billing guidelines

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)
- Each practitioner must identify the diagnosis he/she is personally treating
- Refer to Chapter A-200, Section A-220.82 Concurrent Care for information regarding documentation and billing guidelines

Newborn Care

- *Normal* newborn care is considered the inpatient service provided to a newborn who does not develop complications prior to discharge from the hospital
- 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 recipient 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

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
- Both DHS and HFS are aware of recent issues with newborn eligibility, including coverage that is not backdated to the infant's DOB and multiple RIN situations. Providers who experience these issues should contact the DHS E-RIN Help Desk at 800-843-0872

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 HFS 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 Appendix A-7 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 Chapter 200, Topic 221 Anesthesia for further information and billing guidelines

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
- If the patient experiences a complication, such as an infection, that requires additional visits, submit the claim on paper with supporting documentation for a separately identifiable E/M service and use the modifier 25
- 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 claim form. Ensure that the operative report date is the service date indicated on the claim.

Surgical Services (cont'd)

- Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package
- 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 Chapter A-200, Section A-222 Surgery for further information and billing guidelines

IHW/Family Planning

- The Illinois Healthy Women (IHW) program ended 12/31/14, as many participants became eligible for coverage under ACA adult provisions
- Family planning services remain covered as outlined in the Chapter A-200 Practitioner Handbook, Section A-223:
  - Bill the appropriate CPT code(s) for services provided
  - Use the FP modifier
  - Use the appropriate family planning diagnosis code from the V25 series from ICD-9-CM (or corresponding ICD-10-CM for DOS after September 30, 2015) as appropriate

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 Chapter 200, Topic A-224 Radiology Services for billing guidelines and examples of overlapping studies

Group Psychotherapy

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS has 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.hfs.illinois.gov/assets/062712n1.pdf
- 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.hfs.illinois.gov/assets/072312n1.pdf.

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.

- As a result of the SMART Act effective July 1, 2012, 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 for dates of service on or after February 1, 2013, a $12.00 dispensing fee add-on will apply to other generic and brand name drugs purchased through the 340B program. The April 15, 2013 provider notice posted on the web site at http://www.hfs.illinois.gov/assets/041513n.pdf instructs providers to identify such drugs by modifying the procedure code with "UD" and to include the $12.00 dispensing fee in the total charges. Providers who failed to include the dispensing fee as outlined in this notice may submit a replacement claim.

- Reimbursement for 340B purchased drugs will the be 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.

Submittal of Claims for Multi-Use Vials

- Please reference the November 10, 2014 Informational Notice at http://www.hfs.illinois.gov/assets/111014n2.pdf
- When billing the department for a multi-use vial, providers must only bill 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
- The information contained in the notice at the link provided does not apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs)

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
- Except for the initial office visit, practitioners may only bill for office visits on the same date of service as office-administered chemotherapy when done for a separately identifiable condition and billed with modifier 25

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
- Therapy evaluations and ongoing therapy services are only reimbursable to an enrolled individual therapist or hospital for its salaried therapist
- Individual therapists and hospitals should refer to Chapter J-200, Handbook for Providers of Therapy Services at http://www2.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf and the therapy fee schedule at http://www2.illinois.gov/hfs/SiteCollectionDocuments/therapy_feesched.pdf

***Please be aware any SMART Act or Senate Bill 741 changes supersede information in the handbook, which is undergoing revision**

Provider Fee Schedules

- HFS strives to update the Practitioner Fee Schedule quarterly and is posted at: http://www.hfs.illinois.gov/feeschedule/
- The most recent Practitioner Fee Schedule was posted to the website in May and is effective with dates of service beginning May 1, 2015
- HFS is diligently working toward the release of the updated Practitioners Fee Schedule removing the columns indicating the 16.75% rate reduction which was effective May 1st through June 30, 2015. Please monitor the website for updates.
- The Practitioner Fee Schedule provides information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization. The fee schedule consists of a key, modifier listing, lab panel table with components and rates, and the listing of billable CPT and HCPCS codes.
- Additional fee schedules, such as those for School-based Clinics, Optometry, Chiropractic, Podiatry, Audiology, and Outpatient Therapies, are posted at: http://www.hfs.illinois.gov/reimbursement/

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.
  - Antepartum care services are not required to bill a participant's private insurance carrier prior to billing the department, however practitioners must bill a participant's private insurance carrier prior to billing the department for deliveries
  - Please refer to topic A-223.41 **Prenatal Care** and A-223.44 **Delivery** of Chapter 200 of the Providers Handbook at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf
- 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 appear in Appendix 1 of most Chapter 200 Provider Handbooks
  - Payment amounts
  - TPL date - instructions appear in Appendix 1 of most Chapter 200 Provider Handbooks

**for discrepancies between TPL reported by participants and that seen on MEDI please contact the TPL unit at 217-524-2490

HFS Paper Claim Forms

- **HFS 2360 – Instructions in Chapter 200, Appendix A-1 for:**
  - Physicians & APNs
  - Imaging Centers & Independent Diagnostic Testing Facilities
  - Hospitals billing fee-for-service
  - Local Health Departments
  - FQHC/RHC/ERCs & School-Based Clinics

- **HFS 1443 – Instructions in Chapter 200, Appendix B-1:**
  - Chiropractors
  - Podiatrists
  - Therapists (PT, OT and Speech)
  - Local Education Agencies
  - Audiologists
  - Optometrists
  - SASS (Children's Mental Health)

HFS Paper Claim Forms (cont'd)

- **HFS 2211 – Instructions in Chapter L-200, Appendix L-1:**
  - Independent Laboratories
  - Portable X-ray Companies
- **HFS 3797 – Instructions in Chapter 200, Appendix A-2:**
  - All providers billing Medicare crossovers
- **Links to all Chapter 200 Handbook Appendices may be found at** http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/Chapter200.aspx

HIPAA 5010

- The HIPAA 5010 version of the 837P was fully implemented on May 1, 2012
- The Chapter 300 Companion Guide for 5010 may be viewed at: http://www.hfs.illinois.gov/handbooks/chapter 300.html
- 5010 submissions via batch file or direct data entry 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). Please be aware of this possibility. It is the provider's responsibility to verify all submitted files have been accepted at HFS by checking acknowledgements and claim status.**

Medical Electronic Data Interchange (MEDI)

- **MEDI is available by logging in at www.myhfs.illinois.gov for:**
  - Verifying client eligibility
  - Submitting claims
  - Submitting replacement claims (bill type ‘7’)
  - Submitting voids (bill type ‘8’)
  - Checking claim status (individual claim status is available for 90 days from bill date ; batch status is available for one year from bill date)

- **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)
  - Employees (no limit)

MEDI (cont'd)

- **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, then option 3:**
  - registration
  - digital certificate/password reset
  - administrator/biller authorization
- **The 835 is available to the designated payee**
  - Remittance Advice Remark Codes are national standard codes as published at http://www.wpc-edi.com/codes.
  - For HFS-specific adjudication information, refer to the paper remittance advice form HFS 194-M-1.

Voids & Replacement Claims

- **Voids**
  - May be completed on paper by using the HFS 2292 NIPs Adjustment Form. Forms are free of charge and may be requested online using the Medical Forms Request webpage at: http://www2.illinois.gov/hfs/MedicalProvider/Forms%20Request/Pages/default.aspx. The instructions for completion of the HFS 2292 may be found in Appendix 6 of the Chapter 100 handbook at : http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/Chapter100.aspx
  - May be completed electronically by using bill type '8' to void a single service line or entire claim
- **Replacement Claims**
  - May be completed electronically by using bill type '7'
- **The instructions for electronic voids and replacement claims may be found in the Chapter 300 Companion Guide at** http://www2.illinois.gov/hfs/SiteCollectionDocuments/837p.pdf
- **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

- This remains forthcoming in the future, referring/ordering and prescribing practitioners will be required to be enrolled with Medicaid
- A provider notice will be posted on the HFS website 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

- C03 – illogical quantity
- C17 – place of service illogical
- D01 – duplicate claim – previously paid this provider, this recipient, this DOS, this code
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 / R39 – client enrolled in managed care, provider must bill the plan
- 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
- C97 – No payable service on claim (encounter claims with no payable detail code)
- T21 -- Client has Third Party Liability

Chapter 100 Handbook, Appendix 5 details HFS remittance advice error codes at:
http://www.hfs.illinois.gov/assets/100app5.pdf

Contact Numbers for Billing Questions and Prior Approval

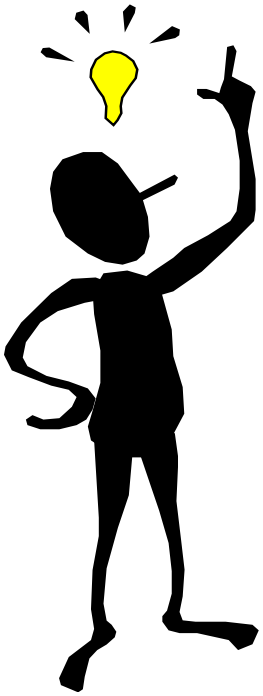
Main Number : 877-782-5565

****Claim status is not available by phone. Claim status is available using MEDI, the 835 ERA, and the paper remittance advice.****

- IMPACT: option 1
- UB04 Billing: option 2
- Billing for Practitioners, including Physicians, Chiropractors, APNs, LHDs, FFS Hospitals, Labs, Radiology, Podiatry: option 3, then option 1
- Billing for Audiologists & Durable Med Equip: option 3, then option 2
- Billing for Transportation : option 3, then option 3
- Billing for Optical : option 3, then option 4
- Billing for LEA, Home Health, Therapies : option 3, then option 5
- Prior Approval for DME : option 5, then option 1
- Prior Approval for Home Health/Therapies : option 5, then option 2

http://www.hfs.illinois.gov

- Laws and Rules: http://www.hfs.illinois.gov/lawsrules
- Handbooks, including appendices: http://www.hfs.illinois.gov/handbooks/
  - Chapter 100 – General Policy and Procedures
  - Chapter 200 – Physician Handbook
  - Chapter 300 – Handbook for Electronic Processing
- Provider Releases and E-Mail Notification for Releases: http://www.hfs.illinois.gov/releases/

QUESTIONS

Due to time constraints, please submit your questions via email to the host and a Q/A will be posted to both the HFS and IHC websites