



Handbook for Providers of Medical Services

Chapter 100 General Policy and Procedures

Illinois Department of Healthcare and Family Services

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GENERAL POLICY AND PROCEDURES
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FOREWORD

PURPOSE

Handbooks have been prepared for the information and guidance of providers who participate in the Illinois Medical Assistance Program and other health care programs funded or administered by HFS. Handbooks state HFS policy with sufficient instructions and guidelines to enable providers to:

- know which services provided to eligible participants are covered;
- submit proper billings for services rendered; and
- make inquiries to the proper source when it is necessary to obtain clarification and interpretation of Department policy and coverage.

Providers will be held responsible for compliance with all policy and procedures contained herein.

FORMAT

A complete handbook consists of two sections:

Chapter 100 contains general policy, procedures and appendices applicable to all participating providers.

Chapter 200 contains specific policy, procedures and appendices applicable to the provision of a specific type or category of service.

A separate Chapter 200 is published for each type of provider or category of service. Each is designated by an alphabetical character. HFS will reissue all Chapter 200 series Handbooks to conform with changes made in this release of Chapter 100. As each is reissued, all providers enrolled for that specific type of service will be notified via a hard copy Provider Notice. Each Handbook will be made available for downloading from the Department's Web site <<http://www.hfs.illinois.gov/handbooks/>>. Hard copies will be available upon request. Requests for Handbooks should be directed to the Provider Participation Unit (PPU). Refer to Topic 101 for the address of the PPU.

The organization and alphabetical numbering system of the reissued Handbooks will be as follows:

Handbook Number	Type of Provider or Service
N-200	Advanced Practice Nurse
G-200	Ambulatory Surgical Treatment Center
E-200	Audiology
B-200	Chiropractor Dentist
M-200	Durable Medical Equipment
D-200	Encounter Rate Clinics
R-200	Home Health
K-200	Hospice
H-200	Hospital
X-200	Imaging Center (currently called Portable X-ray)
L-200	Laboratory
C-200	Long Term Care
O-200	Optometrist, Optician, Optical Company
P-200	Pharmacy
A-200	Physician
F-200	Podiatrist
S-200	School Based Clinics
W-200	Supportive Living Facility
J-200	Therapy (Physical, Occupational and Speech)
T-200	Transportation

Depending on the range of services, a provider may need more than one Handbook from the Chapter 200 series.

Within the Handbooks, Topics are arranged similarly. For example, if any services covered in any handbook are subject to prior approval, the prior approval process will be explained in Topic 211.

Note: The Handbook for Dental Providers is produced and distributed by the Department's dental contractor, Doral Dental of Illinois. Copies of that Handbook, which is titled the Dental Office Reference manual, may be requested by calling Doral Dental Provider Relations at 1-888-281-2076.

MAINTENANCE OF HANDBOOK

The pages of the Handbook are prepared for insertion in a three-ring binder for ease in use. Revisions and supplements to the Handbooks will be released from time to time as operating experience and State or federal laws require policy and procedure changes. Updates and changes to each Handbook will also be published on the Department's Web site at <http://www.hfs.illinois.gov/>

Transmittals of revisions and supplements will be consecutively numbered. It is suggested that providers record receipt of all transmittals and subsequent updating of their copies of Handbooks. It is very important that all appropriate billing staff be provided with copies of all handbook updates.

DEPARTMENT WEB SITE

The Department maintains an Internet Web site at <http://www.hfs.illinois.gov/> Providers are encouraged to browse the Web site to determine which information is important to them.

Chapter 100 of the Provider Handbook is available on the Internet. The Web site address is <http://www.hfs.illinois.gov/handbooks/>

Updates to Chapter 100 will be posted on the Web site as Provider Bulletins at <http://www.hfs.illinois.gov/releases/>

As each Handbook in the Chapter 200 series is updated and released, it will also be made available on the Department's Web site.

The Department also posts many other items of interest on the Web site, including Administrative Rules and other pertinent government Web site addresses.

ADDRESSES AND TELEPHONE NUMBERS

Bureau of Comprehensive Health Services

- Physicians, Chiropractors, Podiatrists, Independent Laboratories, X-ray

Phone: 1-877-782-5565

P.O. Box 19115
Springfield, Illinois 62794-9115
Fax: 217-524-7120

- FQHC, Rural Health Clinic (RHC), Encounter Rate Clinic (ERC), Transportation, Advanced Practice Nurse

P.O. Box 19116
Springfield, Illinois 62794-9116
Fax: 217-524-7120

- Dental, Optometric

201 South Grand Ave. East
Springfield, Illinois 62763-0001
Fax: 217-524-7120

- Prior Approval – Pharmacy

P.O. Box 19117
Springfield, Illinois 62794-9117
Fax: 217-524-7264

- Durable Medical Equipment, Audiology Home Health Services, Speech, Occupational and Physical Therapy

P.O. Box 19126
Springfield, Illinois 62794-9126
Fax: 217-524-7120

- Prior Approval – Medical Equipment, Home Health Services, Therapies

P.O. Box 19124
Springfield, Illinois 62794-9124
Fax: 217-524-7194

- UB-92 Claims for Inpatient Hospital, Outpatient Hospital, Renal Dialysis, Ambulatory surgical Treatment Centers

P.O. Box 19128
Springfield, Illinois 62794-9128
Fax: 217-524-4283

- Hospice

P.O. Box 19110
Springfield, Illinois 62794-9110
Fax: 217-524-4283

Provider Participation Unit

Phone: 217-782-0538
Fax: 217-557-8800

- Enrollment and Handbooks

P.O. Box 19114
Springfield, Illinois 62794-9114

Bureau of Contract Management

Phone: 217-524-7478
 Fax: 217-524-7535

- Marketing
- Contract Monitoring and Administration

201 South Grand Ave. East
 Springfield, Illinois 62763

Fraud and Abuse Hotline

Phone: 1-800-252-8903

Bureau of Long Term Care

Phone: 217-782-0545
 Fax: 217-524-7114

- Supportive Living Facilities
- Nursing Facilities

201 South Grand Avenue East
 Springfield, Illinois 62763

Third Party Liability

Phone: 217-524-2490
 Fax: 217-557-1174

- Insurance Coverage Changes

P.O. Box 19120
 Springfield, Illinois 62794-9120

AVRS Provider Health Care Hotline

Phone: 1-800-842-1461
 Available 24 hours/day

- Eligibility Information

**Department of Human Services (DHS)
Helpline**

Phone: 1-800-843-6154
 Fax: 217-524-0083

Office of Health Finance

Phone: 217-782-1630
 Fax: 217-782-2812

- Hospital Cost Reports
- Long Term Care Facility Cost Reports

201 South Grand Avenue East
 Springfield, Illinois 62763

Bureau of Medicaid Integrity

Phone: 217-782-2121
 Fax: 217-782-1745

- Audits of Medical Providers

404 North 5th Street
 Springfield, Illinois 62702

ACRONYMS AND ABBREVIATIONS

AABD – Aid to the Aged, Blind and Disabled

AABD MANG – Aid to the Aged, Blind and Disabled receiving Medical Assistance only

AVRS – Automated Voice Response System

CMS – Centers for Medicare and Medicaid Services

CPT – Current Procedural Terminology, a nationally standardized system for coding procedures and services performed by practitioners

DCFS – Department of Children and Family Services

DEPARTMENT – Department of Healthcare and Family Services

DHS – Department of Human Services

DHS ORS – Department of Human Services/Office of Rehabilitation Services

DOC – Department of Corrections

DPA – Department of Public Aid

DPH – Department of Public Health

DSCC – Division of Specialized Care for Children

ECC – Electronic Claims Capture

ECP – Electronic Claims Processing

EFT – Electronic Funds Transfer

EPSDT – Early and Periodic Screening, Diagnosis and Treatment

ERC – Encounter Rate Clinic

FCRC – Family Community Resource Center

FQHC – Federally Qualified Health Center

HCPCS – Healthcare Common Procedure Coding System, a nationally standardized system for coding services and supplies

HFS – Healthcare and Family Services

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

ICD-10-CM – International Classification of Diseases, 10th Edition, Clinical Modification, a nationally standardized system for coding diagnoses and procedures

MCCN – Managed Care Community Network

MCO – Managed Care Organization

MEDI – Medical Electronic Data Interchange

NCPDP – National Council of Prescription Drug Program

NDC – National Drug Code, a nationally standardized system for coding pharmaceuticals and certain medical supplies

NIPS – Non-Institutional Provider Services

NNSF or NSF – New National Standard Format

PCP – Primary Care Physician or Primary Care Pharmacy

QMB – Qualified Medicare Beneficiary

RHC – Rural Health Clinic

REV – Recipient Eligibility Verification System

RRP – Recipient Restriction Program

TANF – Temporary Assistance to Needy Families

TPL – Third Party Liability

CHAPTER 100

GENERAL POLICY AND PROCEDURES

100 HFS MEDICAL PROGRAMS – BASIC PROVISIONS, AUTHORITY AND OBJECTIVE

For consideration for payment by the Department under any of its authorized programs, covered services must be provided to an eligible participant by a medical provider enrolled for participation in the Illinois Medical Assistance Program. Services provided must be in full compliance with applicable federal and state laws, Department Administrative Rules (89 Ill. Adm. Code Chapter 101), the general provisions contained in Chapter 100, General Policy and Procedures, and the policy and procedures contained in the Chapter 200 series Handbook that applies to the specific type of service or type of provider.

The objective of the Department’s Medical Programs is to enable eligible participants to obtain necessary medical care. “Necessary medical care” is that which is generally recognized as standard medical care required because of disease, infirmity or impairment. Preventive care is covered in certain circumstances, as specified in Topic 103 and in the Chapter 200 Series Handbooks.

Payment for necessary medical care and certain preventive services, as specified in Chapter 100, Topic 103, is made to participating providers when it is not available without charge or is not covered by health insurance or other liable third parties. As specified by rule, prior approval requirements may be imposed for some services.

Both fiscal considerations and good administrative practice require the imposition of certain limitations and controls on the kind and amount of medical care covered by the Department’s Medical Programs. Careful review of the Handbook material will enable providers to identify specific program coverages and limitations.

Programs under which the Department is authorized to make payments include the following.

100.1 MEDICAL ASSISTANCE PROGRAM

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act (Medicaid). It is administered by HFS under the Illinois Public Aid code. The Department has statutory responsibility and authority for the formulation of medical policy in conformance with federal and State requirements.

100.2 ALL KIDS PROGRAM

All Kids, a joint federal and state funded program, operates under Title XIX and XXI of the Social Security Act, the Illinois Public Aid Code [305 ILCS 5/1-1 et seq.] and the Children's Health Insurance Program Act [215 ILCS 106] that authorize HFS to administer an insurance program to assist families in providing or purchasing health insurance benefits for their children. Through All Kids, the Department provides health benefits coverage to eligible families, children and pregnant women by providing health care benefits or by subsidizing the cost of private health insurance, including employer health insurance.

Four All Kids plans are encompassed by this Handbook:

- All Kids Assist Plan – This plan pays for a child's health care with no copayments or premiums from the participant.
- All Kids Share Plan – This plan pays for a child's health care with a low copayment due from the participant on certain services. Refer to Topic 114.
- All Kids Premium Plan – This plan requires participants to pay a low premium each month and a low copayment on certain services. Refer to Topic 114.
- Moms & Babies – This plan covers pregnant women throughout pregnancy, 60 days postpartum and babies for the first year of the baby's life with no copayments or premiums from the participant.

100.3 TRANSITIONAL ASSISTANCE PROGRAM (CITY OF CHICAGO) AND STATE FAMILY AND CHILDREN ASSISTANCE PROGRAM (CITY OF CHICAGO)

Medical coverage for participants in the Transitional Assistance Program and the Family and Children Assistance Program is administered by HFS under Article VI of the Illinois Public Aid Code (305 ILCS 5/6-1 et seq).

The Department has statutory responsibility and authority for the formulation of medical policy in conformance with state requirements. Both programs are funded by the state, with no federal participation.

100.4 QMB PROGRAM

The Department's Qualified Medicare Beneficiary (QMB) Program assists persons who are eligible for Medicare with the costs of Medicare cost-sharing, i.e. premiums, deductibles and coinsurance. QMB/Medicaid participants are enrolled in Medical Assistance as well as Medicare. QMB Only participants are eligible only for

payment of Medicare cost sharing. The only items considered for payment for QMB Only participants are the deductibles and coinsurance on services which are covered by Medicare.

100.5 STATE RENAL DIALYSIS PROGRAM

The State Renal Dialysis Program is operated by the Department under the authority of the Renal Disease Treatment Act (410 ILCS 430). This program covers the cost of renal dialysis services for eligible Illinois residents diagnosed with chronic renal failure.

100.6 STATE HEMOPHILIA PROGRAM

The State Hemophilia Program is operated by the Department under the authority of the Hemophilia Care Act (410 ILCS 420). This program provides assistance to eligible patients for antihemophilic factors, annual comprehensive visits and other outpatient medical expenses related to the disease.

100.7 STATE SEXUAL ASSAULT SURVIVORS EMERGENCY TREATMENT PROGRAM

The Illinois Sexual Assault Survivors Emergency Treatment Program is administered under the authority of the Sexual Assault Survivors Emergency Treatment Act (410 ILCS 70). This program provides payment for medical expenses for sexual assault survivors who seek emergency services from a certified hospital and who are not eligible for Medical Assistance or All Kids nor are covered for these services by a policy of health insurance. It is not necessary for the assault to be proven in order for services to be covered.

For hospital certification to participate in the Sexual Assault Survivors Emergency Treatment Program, contact:

Illinois Department of Public Health
Office of Health Care Regulations
525 W. Jefferson, 5th floor
Springfield, IL 62761
Telephone: 217-782-2913

100.8 HEALTH BENEFITS FOR PERSONS WITH BREAST OR CERVICAL CANCER

The Department implemented Health Benefits for Persons with Breast or Cervical Cancer effective August 1, 2001. The program was expanded effective September 1, 2006 under the Treatment Act Expansion. This program assists uninsured persons who have been found to have breast or cervical cancer or a precancerous condition.

100.9 HEALTH BENEFITS FOR WORKERS WITH DISABILITIES (HBWD)

The Department implemented Health Benefits for Workers with Disabilities effective December 1, 2001. This program assists persons with disabilities who wish to go to work, or to increase their earnings without the fear of losing Medicaid benefits.

101 PROVIDER PARTICIPATION

To receive payment for medical care, services and supplies provided to individuals eligible for any of the HFS Medical Programs, a provider must enroll and be approved for participation by HFS.

To enroll for participation, providers shall:

- Hold a valid, appropriate license where state law requires licensure of medical practitioners, agencies, institutions and other medical vendors;
- Be certified for participation in the title XVIII Medicare program where federal or state rules and regulations require such certification for the Title XIX Medicaid participation;
- Be certified for Title XIX Medicaid when federal or state rules and regulations so require;
- Provide enrollment information to the Department in the prescribed format (see Topic 201 in the chapter 200 series), and notify the Department in writing promptly whenever there is a change in any such information which the provider has previously submitted;
- Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care service to eligible participants;
- Have a written provider agreement on file with the Department.

PROVIDER ENROLLMENT PROCEDURE

To participate in the HFS Medical Programs, providers must complete a Provider Enrollment Application. To obtain an enrollment application, contact the Provider Participation Unit. Requests may be made by mail, e-mail or phone at:

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

Telephone: 217-782-0538

Fax: 217-557-8800

E-Mail: hfs.PPU@illinois.gov

Web site: <http://www.hfs.illinois.gov/enrollment/>

The Department will confirm that enrollment has been completed by sending a Provider Information sheet to the provider. Further information on this process for each type of provider is described in Topic 201 in the Chapter 200 series.

101.1 PARTICIPATION REQUIREMENTS

To be approved for participation, a provider must agree to:

- verify eligibility of the patient prior to providing each service (not applicable where prohibited by law, for example, emergency ambulance services or hospital emergency room services);
- allow all patients the choice of accepting or rejecting medical or surgical care or treatment;
- inform patients prior to providing a noncovered service for which the patient will be held financially liable, that payment for such service cannot be made by the Department;
- provide supplies and services in full compliance with all applicable provisions of state and federal laws and regulations pertaining to nondiscrimination and equal employment opportunity, including, but not limited to:
 - full compliance with title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin;
 - full compliance with section 504 of the Rehabilitation Act of 1973 and Part 84 of title 45 of the code of Federal Regulations, which prohibit discrimination on the basis of handicap; and
 - without discrimination on the basis of religious belief, political affiliation, sex, age or disability;
- comply with the requirements of applicable federal and state laws and not engage in practices prohibited by such laws;
- hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding patients;
- furnish to the Department, in the format and manner requested by it, any information it requests regarding payments for providing goods or services or supplies to patients by the provider, his or her agent, employer or employee;
- provide services and supplies to patients in the same quality and mode of delivery as are provided to the general public, and charge the Department in amounts not to exceed the provider's usual and customary charges;
- accept as payment in full the amounts established by the Department, except in limited instances involving allowable spenddown or co-payments, as described in Topics 113 and 114:
 - if a provider accepts an individual eligible for medical assistance from the Department as a Medicaid recipient, such provider must not bill, demand, or otherwise seek reimbursement from that individual or from a financially responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department. For purposes of this subsection, "accepts" shall be deemed to include:
 - an affirmative representation to an individual that payment for services will be sought from the Department;

- an individual presents the provider with his or her medical card and the provider does not indicate that other payment arrangements will be necessary; or
- billing the Department for the covered medical service provided an eligible individual.
- If an eligible individual is entitled to medical assistance with respect to a service for which a third party is liable for payment, the provider furnishing the service may not seek to collect from the individual payment for that service if the total liability of the third party for that service is at least equal to the amount payable for that service by the Department;
- accept assignment of Medicare benefits for participants eligible for Medicare, when payment for services to such persons is sought from the Department;
- in the case of long term care providers, assume liability for repayment to the Department of any overpayment made to the facility regardless of whether the overpayment was incurred by a current owner or operator or by a previous owner or operator.

These requirements are further detailed in 89 Illinois Administrative Code 140, Subpart B and in relevant Topics throughout the provider handbooks.

101.2 TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in the Department's Medical Programs at any time, unless the provider has a contractual relationship with the Department which provides otherwise.

Exception: In the case of long term care providers, facilities must give written notice at least 60 days prior to the date of termination. For a complete description of these requirements, refer to the Handbook for Long Term Care Facilities.

Written notification of voluntary termination is to be sent to:

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

The Department may terminate or suspend a provider agreement or a provider's eligibility to participate in the Department's Medical Programs pursuant to administrative proceedings. Department rules concerning the bases for such terminations or suspensions are set out in 89 Illinois Administrative Code 140.16. Department rules concerning administrative proceedings involving terminations or suspensions of medical vendors are set out in 89 Illinois Administrative Code 104, Subpart C.

The occurrence of a termination, either voluntary or involuntary, does not preclude the recovery of identified overpayments.

102 PATIENT ELIGIBILITY

Payment can be made by the Department only for covered medical care and services provided to individuals who are eligible on the date services are actually provided. It is the responsibility of the provider to verify a patient's eligibility prior to providing services, except where prohibited by law, for example, emergency ambulance services or hospital emergency room services.

This Topic provides a brief overview of eligibility determination processes. Topic 108.4 explains how information on the eligibility card can be used to determine which agency and office is responsible for eligibility issues on a particular patient.

102.1 MEDICAL ASSISTANCE PROGRAM

Under an interagency agreement with HFS, the Department of Human Services (DHS) takes applications and determines the eligibility of individuals and families for the Medical Assistance Program. HFS' All Kids unit can determine eligibility for children, pregnant women, parents and caretaker relatives who apply by means of a mail-in or Web application. The Department of Children and Family Services (DCFS) is responsible for children who are covered by Medicaid and who are wards of the State or whose care is subsidized by DCFS. All persons covered under the Medical Assistance program are issued a monthly MediPlan Card (Form HFS 469) by DHS and HFS assumes responsibility for the processing and payment of medical services.

Evidence of eligibility is demonstrated by any of the following:

- Form HFS 469, MediPlan Card (see Topic 108.1)
- Form HFS 1411CF, Temporary MediPlan Card (see Topic 109)
- Form HFS 1411, Temporary MediPlan Card (see Topic 109)
- Form HFS 469D, Temporary MediPlan Card (see Topic 109)

102.2 ALL KIDS PROGRAM

Eligibility for this program is determined by the Department's central All Kids Unit or, through an interagency agreement, by the Department of Human Services (DHS).

Evidence of eligibility for All Kids Assist and Moms and Babies is demonstrated by any of the following medical cards:

- Form HFS 469, MediPlan Card (see Topic 108.1)
- Form HFS 1411CF, Temporary MediPlan Card (see Topic 109)
- Form HFS 1411, Temporary MediPlan Card (see Topic 109)

Evidence of eligibility for All Kids Share and All Kids Premium is demonstrated by the following medical card:

- Form HFS 469KC, All Kids Identification Card (see Topic 108.2)

102.3 TRANSITIONAL ASSISTANCE PROGRAM (CITY OF CHICAGO) AND STATE FAMILY AND CHILDREN ASSISTANCE PROGRAM (CITY OF CHICAGO)

Under an interagency agreement with HFS, the Department of Human Services (DHS) processes applications and determines the eligibility of individuals and families for both programs.

Evidence of eligibility is demonstrated by any of the following:

- Form HFS 469, MediPlan Card (see Topic 108.1)
- Form HFS 1411CF, Temporary MediPlan Card (see Topic 109)
- Form HFS 1411, Temporary MediPlan Card (see Topic 109)

102.4 QMB PROGRAM

Under an interagency agreement with HFS, the Department of Human Services (DHS) processes applications and determines the eligibility of individuals and families for Medicare cost-sharing under the QMB Program.

Evidence of eligibility is demonstrated by any of the following:

- Form HFS 469, MediPlan Card (see Topic 108.1)
- Form HFS 1411CF, Temporary MediPlan Card (see Topic 109)
- Form HFS 1411, Temporary MediPlan Card (see Topic 109)

102.5 STATE RENAL DIALYSIS PROGRAM

The application package is supplied by the Department to social workers in renal dialysis centers. The social workers assist the patient in completing the application and submit it to the Department. Department staff performs a financial and eligibility evaluation and determine what the patient's participation fee, if any, will be.

No eligibility card is issued. Questions regarding applications or the eligibility of participants in the Renal Dialysis Program should be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

102.6 STATE HEMOPHILIA PROGRAM

Eligibility for this program is determined by the Department. Department staff conducts a financial evaluation and determine what the patient's participation fee, if any, will be. Once they are approved for coverage, participants are sent an application every fiscal year to reapply.

Applications are returned to
Department of Healthcare and Family Services
Attn: Hemophilia Program
P. O. Box 19129
Springfield, Illinois 62794-9129

No eligibility card is issued. Questions regarding applications or the eligibility of participants in the State Hemophilia Program should be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

102.7 STATE SEXUAL ASSAULT SURVIVORS EMERGENCY TREATMENT PROGRAM

The Illinois Sexual Assault Survivors Emergency Treatment Program covers medical expenses for sexual assault survivors who seek emergency services from a certified hospital and who are not eligible for Medical Assistance or All Kids nor are covered for these services by a policy of health insurance.

Another resource for these patients is

Office of the Attorney General of Illinois
Crime Victims Compensation Program
100 W. Randolph St., 13th Floor
Chicago, Illinois 60601
Telephone (312) 814-2581

Other inquiries on this program should be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

102.8 HEALTH BENEFITS FOR PERSONS WITH BREAST OR CERVICAL CANCER

Eligibility for this program is determined by the Department's Breast and Cervical Cancer (BCC) Eligibility Unit.

Evidence of eligibility for the Breast and Cervical Cancer Program is demonstrated by any of the following medical cards:

- Form HFS 469, MediPlan Card (see Topic 108.1)
- Form HFS 1411CF, Temporary MediPlan Card (see Topic 109)
- Form HFS 1411, Temporary MediPlan Card (see Topic 109)

Questioning regarding the Breast and Cervical Cancer Program should be directed to the Department of Public Health Helpline at 1-888-522-1282.

102.9 HEALTH BENEFITS FOR WORKERS WITH DISABILITIES (HBWD)

Eligibility for this program is determined by the Department's Health Benefits for Worker with Disabilities (HBWD) unit in Springfield.

Evidence of eligibility for the Health Benefits for Workers with Disabilities Plan is demonstrated by any of the following:

- Form HFS 469, MediPlan Card (see Topic 108.1)
- Form HFS 1411CF, Temporary MediPlan Card (see Topic 109)
- Form HFS 1411, Temporary MediPlan Card (see Topic 109)

Applications are returned to:

Health Benefits for Workers with Disabilities
P.O. Box 19145
Springfield, Illinois 62794-9145

Questioning regarding the Health Benefits for Workers with Disabilities should be directed to 1-800-226-0768.

102.10 STATE AGENCY CONTACTS

Unless otherwise noted above, the contact procedures for inquiries to the State agencies responsible for determining eligibility are described below.

DHS Family Community Resource Center (FCRC) are organized and supervised by regions. When providers need to make contact with DHS regarding a participant, the FCRC that serves the county in which the participant lives is to be contacted. In Cook County, providers should contact the appropriate neighborhood FCRC.

The Department of Children and Family Services (DCFS) has responsibility for administering its own cases. Eligibility for DCFS cases is determined by DHS staff located within the DCFS facility. When providers need to make contact with DCFS regarding a participant, the DCFS Regional Medical Liaison that serves the county in which the child is living is to be contacted.

Inquiries to HFS regarding eligibility for any medical program may be directed to 1-800-842-1461.

102.11 PRIOR AND RETROACTIVE COVERAGE

Once their coverage begins, participants in the Medical Assistance and All Kids programs receive monthly medical cards that document their eligibility and coverage limitations. See Topic 108 for examples and an explanation of the contents of the monthly MediPlan and All Kids Cards.

When they initially apply for coverage, Medical Assistance, All Kids Assist and Moms and Babies applicants may request that their coverage be backdated to cover services they may have received for up to three months prior to month of their application. The first time children are approved for All Kids Share or All Kids Premium Level 1, the children may be eligible for payment of medical services received from two weeks before the date of application until the date All Kids coverage begins.

If a participant's request for retroactive coverage is granted, it is sometimes documented by a Temporary Identification Card. Examples and an explanation of Temporary Identification Cards can be found in Topic 109. Prior coverage may also be documented by a letter from the Department's central All Kids unit.

Retroactive coverage for Medical Assistance and All Kids Program participants is not always documented by a Temporary Identification Card or letter. If the participant cannot produce such documentation, but requests that a provider bill the Department for medical services or items provided during the retroactive or prior coverage period, the provider may verify eligibility via the Recipient Eligibility Verification system (see Topic 131.2), the Department's toll-free AVRS Provider Health Care Hotline (1-800-842-1461), or by contacting the responsible administrative office as described in Topic 102.10.

103 COVERED SERVICES

The range of services for which the Department will pay varies depending on the program or plan under which a participant is covered.

Topic 108 provides facsimiles of the MediPlan and All Kids Cards and describes how to determine which persons are eligible for each of the following lists of services, using the Case ID Category numbers and eligibility restriction messages contained on the Card.

103.1 MEDICAL ASSISTANCE AND ALL KIDS PROGRAMS

The medical services that are covered for participants in Medical Assistance (Medicaid), All Kids Assist and Moms and Babies include the following.

- Physician services
- Hospital Inpatient Services
- Hospital Emergency Room Visits
- Hospital Ambulatory Services
- Ambulatory Surgical Treatment Center Services
- Encounter Rate Clinic Visits
- Pharmacy Services
- Laboratory/X-ray Services
- Optical Services/supplies
- Chiropractic Services
- Hospice Services
- Optometrist Services
- Advanced Practice Nurse Services
- Audiology Services
- Dental Services
- Family Planning Services and Supplies
- Podiatric Services
- Transportation to secure medical services
- Long Term Care Services
- Home Health Agency Visits
- Physical, Occupational and Speech Therapy Services
- Renal Dialysis Services
- Medical Supplies, Equipment, Protheses and Orthoses
- Respiratory Equipment and Supplies

In addition to the services listed above, certain medical services that are funded through other state agencies are covered for participants in Medical Assistance (Medicaid), All Kids Assist and Moms and Babies. These include:

- Services provided through a waiver approved under Section 1915(c) of the Social Security Act (funded through the Department on Aging and DHS),

- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option (funded through DHS and DCFS), and
- Subacute alcohol and substance abuse treatment services (funded through DHS).

Note: Individuals participating in Medical Assistance, All Kids Assist and Moms and Babies receive a MediPlan Card. See Topic 108.1.

The medical services that are covered for participants in All Kids Share and All Kids Premium Level 1 are the same as those listed above, with the following exceptions:

- those services provided through a waiver approved under Section 1915(c) of the Social Security Act, and
- abortion services.

Note: Individuals participating in All Kids Share and All Kids Premium receive an All Kids Card see Topic 108.2.

103.2 STATE TRANSITIONAL ASSISTANCE PROGRAM (CITY OF CHICAGO ONLY)

The following medical services are covered for participants in the Transitional Assistance Program:

- Physician services
- Laboratory/X-ray Services
- Vital Pharmacy Services and vital Medical Supplies, Equipment, Prosthetic Devices and Respiratory Equipment. (“Vital” means those items or services that are necessary for life maintenance or to avoid life-threatening situations.)
- Transportation to secure medical services
- Dental Services
- Optical Services and Supplies
- Chiropractic Services
- Podiatric Services
- Hospice Services
- Long Term Care Services (subject to prior approval)
- Home Health Agency Services
- Encounter Rate Clinic Visits
- Family Planning Services and Supplies

Note: Hospital services of any type are not covered for participants of the Transitional Assistance Program. This limitation on coverage also applies for any other service if it is billed by the hospital.

103.3 STATE FAMILY AND CHILDREN ASSISTANCE PROGRAM (CITY OF CHICAGO ONLY)

The following medical services are covered for adult participants in the State Family and Children Assistance Program:

- Physical Services
- Vital Pharmacy Services and vital medical Supplies, Equipment, Prosthetic Devices and Respiratory Equipment. (“Vital” means those items or services that are necessary for life maintenance or to avoid life-threatening situations.)
- Hospital Inpatient Services and Hospital Ambulatory Services (and all ancillaries) for surgical procedures, renal dialysis, cancer therapy or follow-up burn treatment. (Note Physical rehabilitation services and psychiatric services are not covered.)
- Hospital Emergency Room visits
- Transportation to secure medical services
- Laboratory/X-ray Services
- Dental Services
- Optical Services and Supplies
- Chiropractic Services
- Podiatric Services
- Hospice Services
- Long Term Care Services (subject to prior approval)
- Home Health Agency Services
- Encounter Rate Clinic Visits
- Family Planning Services and Supplies

Children in the State Family and Children Assistance Program are covered for the full range of services described in Topic 103.1, without exception.

103.4 EMERGENCY SERVICES DEFINED

Throughout all the programs administered by the Department, the following definition of “emergency services” is used, unless otherwise specified:

The words “emergency services” mean those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or their unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

103.5 STATE RENAL DIALYSIS PROGRAM

The only medical service covered for participants in the State Renal Dialysis Program is the dialysis itself.

103.6 STATE HEMOPHILIA PROGRAM

Medical services covered for participants in the State Hemophilia Program vary according to the age of the participant.

For children under the age of 21, the Department reimburses for blood clotting factor only. Other medical expenses are reimbursed by the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC).

For adults, the Department reimburses for blood clotting factor and other medical expenses related to the disease, including:

- Two comprehensive exams per year
- Hospital Outpatient Services
- Hospital Emergency Room Visits
- Physician Services
- Laboratory Services
- Blood Transfusion
- Medical Supplies

The above services are covered only when they are directly related to the participant's hemophilia.

103.7 STATE SEXUAL ASSAULT SURVIVORS EMERGENCY TREATMENT PROGRAM

The following medical services are covered for participants in the State Sexual Assault Survivors Emergency Treatment Program:

- Physician Services
- Hospital Emergency Room Visits
- Transportation to the Hospital Emergency Room
- Drugs and Medical Supplies
- Follow-up services such as physician, laboratory and pharmacy, for a period of 90 days

The above services are covered only when they are directly related to an alleged sexual assault. The Department will allow the provider to use their judgment to determine whether the services being provided are related to the sexual assault.

103.8 HEALTH BENEFITS FOR PERSON WITH BREAST OR CERVICAL CANCER

Participants in the Breast and Cervical Cancer Program receive the same medical benefits as the participants in the Medical Assistance Program. Refer to Topic 103.1

103.9 HEALTH BENEFITS FOR WORKERS WITH DISABILITIES. (HBWD)

Participants in the Health Benefits for Workers with Disabilities Program receive the same medical benefits as the participants in the Medical Assistance Program. Refer to Topic 103.1.

104 SERVICES NOT COVERED

Services and supplies for which payment will not be made under any of the Department's Medical Programs include, but are not limited to, the following:

- Services available without charge
- Services prohibited by state or federal law
- Experimental procedures
- Research oriented procedure
- Medical examinations required for entrance in to adult educational or vocational program
- Autopsy examinations
- Routine (well-person) examinations
- Artificial insemination
- Abortion except in accordance with the provisions of 89 Ill. Admin Code 140.413(a)(1)
- Medical or surgical procedures performed for cosmetic purposes
- Medical or surgical transsexual treatment services
- Diagnostic or therapeutic procedures related to secondary infertility/sterility
- Acupuncture
- Subsequent treatment for venereal disease, when such services are available free of charge through state and/or local health agencies
- Medical care provided by mail or telephone, except for approved Telemedicine services described in Chapter 200 (Note: this does not prohibit the mailing of medically necessary covered item, for example, prescription drugs sent to a patient by a mail-order pharmacy.)
- Unkept appointments
- Services provided by terminated or barred providers
- Preparation of routine records, forms and reports
- Visits with persons other than a patient, such as family members or long term care facility staff.
- Items or services for which medical necessity is not clearly established
- Services provided only, or primarily, for the convenience of patients or their families
- Services or supplies not personally rendered by the billing provider, unless specifically allowed in this handbook or in the Chapter 200 series or otherwise specifically authorized in writing by the Department.

Deceased people are not eligible for services, even though the Department's eligibility files may still temporarily show that they are active, covered participants. Payments for services rendered after the death of a participant will be recovered by the Department. Other action may be taken as appropriate, including possible civil or criminal fraud prosecution where warranted.

Chapter 200 may contain other exclusions, which are specific to a provider type or category of service.

105 MANAGED CARE ORGANIZATIONS (MCO)

Some participants have prepared health services, contracted for by the Department, through voluntary enrollment in a Managed Care Organization (MCO). A Managed Care Organization (MCO) may be a Health Maintenance Organization (HMO) or a Managed Care Community Network (MCCN).

An MCO is responsible for providing or arranging and making reimbursement for all covered Medical Assistance services, with the exception of dental services, optical services (vision refractions and corrective lenses) and under certain circumstances, family planning services. An MCO is responsible for only limited long term care facility services.

Participants enrolled in MCOs will receive medical cards with the following message:

MANAGED CARE ENROLLEE(S): Services may require payment authorization.

Before providing services to any participant with a MANAGED CARE ENROLLEE card, the provider should be sure of the arrangements for reimbursement. In no instance will the Department reimburse a provider when the services is one for which the MCO is contractually responsible.

Included as covered are the following services and benefits which will be provided to participants by their MCO whenever medically necessary.

- Inpatient Hospital Services (including hospitalization for acute medical detoxification and dental hospitalization in case of trauma or when related to a medical condition)
- Inpatient Psychiatric Care
- Outpatient Hospital Services
- Laboratory and X-ray Services
- Nursing Facility (Long Term Care) Services for the first 90 days
- Physicians Services, including psychiatric care
- Home Health Agency Services
- Clinic Services
- Pharmacy Services (including drugs prescribed by a dentist participating in the Department's Medical Programs), provided they are filled by an MCO network pharmacy
- Physical, Occupational and Speech Therapies.
- Transportation to secure medical services
- Family Planning Services
- Services required to treat a condition diagnosed as a result of Healthy Kids (EPSDT) services
- Blood, blood components, and the administration thereof
- Podiatric services
- Durable and nondurable Medical Equipment and Supplies

- Chiropractic Services
- Emergency Services
- Routine care in conjunction with certain investigational cancer treatments
- Audiology Services
- Assistive/augmentative Communication Devices
- Behavioral Health Services, including subacute alcohol and substance abuse services and mental health services
- Hospice Services
- Medical procedures performed by a dentist
- Nurse Midwife services
- Orthotic/prosthetic devices, including prosthetic devices or reconstructive surgery incidental to a mastectomy
- Transplants
- Diagnosis and treatment of medical conditions of the eye (may be provided by an optometrist operating within the scope of his or her license)
- Services to prevent illness and promote health

The Department will pay participating providers directly covered services that are not included in an MCO's contract. In the case of dental services, Doral Dental of Illinois, the Department's dental administrator, will make payment.

Family planning services are the contractual responsibility of the MCO when a covered service is provide by any provider in the MCO's network. Participants enrolled in an MCO can obtain family planning services out-of-network from any enrolled provider. Family planning services performed by an out-of-network provider may be billed directly to the Department.

106 RECIPEINT RESTRICTION PROGRAM (RRP)

The Department identifies participants who overuse medical services. When the Department determines that a Medical Assistance or All Kids participant has received medical or pharmacy services in excess of need or in such a manner as to constitute an abuse of the program, the Department restricts the participant to a Primary Care Physician (PCP) or Primary Care Pharmacy or both, or to a Managed Care Organization (MCO).

When a participant is restricted, the participant will be notified in writing and given the opportunity to select a Primary Care Physician or Pharmacy or both, or to select an MCO. In the event that a participant does not select a Primary Care Physician or Pharmacy or both or an MCO, a Primary Care Physician or Pharmacy or both will be designated by the Department for the participant.

If a participant has been restricted, the MediPlan or All Kids Card will contain notice of this restriction and show the name of the Primary Care Physician or Pharmacy or both or the MCO. In the event that a Temporary Card is issued, the card will contain a message of pending restriction.

The PCP and pharmacy restriction messages are as follows:

- The primary physician named below must provide or authorize the following services on a non-emergent basis: physician, pharmaceutical, clinical, outpatient hospital, laboratory and podiatric, if applicable.
- The primary pharmacy named below must supply or authorize all drugs.

A combination of both messages will appear if the individual is restricted to both a Primary Care Physician and Primary Care Pharmacy.

The MCO restriction message is as follows:

MANAGED CARE ENROLLEE: Services may require payment authorization

Providers who have questions about a participant's RRP status or whether a given service to a restricted participant requires authorization may call the Department's toll-free RRP hotline at 1-800-325-8823.

The Department will not pay for restricted services that are provided on a nonemergency basis without prior written authorization of the designated Primary Care Physician or Pharmacy. This authorization will be on the completed Form HFS 1662, Primary Care Physician Referral Authorization, originated by the Primary Care Physician or Pharmacy.

106.1 MEDICAL SERVICES RESTRICTED BY RRP

The following medical services may only be provided to restricted participants when authorized by the Primary Care Physician or Pharmacy via Form HFS 1662, Primary Care Provider Referral Authorization or when the PCP or Primary Care Pharmacy is the billing provider.

When such designation is made, all physician, drug, clinic, laboratory and podiatric services provided to the participant on a nonemergent basis must be provided or authorized by the Primary Care Physician or Pharmacy, as appropriate. Emergency services, as defined in Topic 103.4, may be provided without prior authorization from the PCP or Primary Care Pharmacy.

The Department will not pay for the following services if they are provided on a nonemergency basis unless prior written authorization (Form HFS 1662) has been received from the Primary Care Physician or Primary Care Pharmacy designated on the restricted participant's MediPlan Card or Temporary Card. When the following services are provided on an emergency basis, authorization (Form HFS 1662) must be obtained from the PCP after service is performed.

- Physicians
- Outpatients Hospital – Scheduled or Elective Procedures
- Laboratory Services
- Outpatient Hospital Services
- Encounter Rate Clinics – FQHCs, RHCs, and ERCs
- Independent Laboratories – Form HFS 1662 is not required if the referring practitioner is PCP
- Pharmacy – Form HFS 1662 is not required if the prescribing practitioner is the PCP
- Podiatric Services
- Outpatient Hospital Clinic

See Topic 112.6 for instructions on billing restricted services.

106.2 MEDICAL SERVICES NOT RESTRICTED BY RRP

The following medical services are not affected by the Recipient Restriction Program and do not require Form HFS 1662, Primary Care Physician Referral Authorization.

- Dental Care – provided through the Department's Dental Contractor
- Hospital Services – Inpatient and Emergency Services
- ESRD Renal Dialysis Services
- Home Health Care
- Hospice Services
- Chiropractic Services
- Medical Equipment

- Optical/Optician Services
- Long Term Care Services
- Transportation Services

106.3 RRP RESTRICTION IN AN MCO

When a participant is restricted and chooses to enroll in an MCO, that participant is subject to the MCO's policies regarding services, which do or do not require the authorization of PCP. Refer to Topic 105.

108 IDENTIFICATION CARDS

MediPlan and All Kids are issued monthly. Some children served by DCFS are issued cards on an annual basis. A family may receive more than one card per month in instances where the number of persons in the case or the length and number of messages on the card are greater than the space available for printing. If medical coverage is restricted in any way, a printed message will appear on the card.

Participants in the State Renal Dialysis Program, the State Sexual Assault Survivors Emergency Treatment Program and the State Hemophilia Program do not receive identification cards. Participants in All Kids Rebate do not receive a card from the Department, but may have an identification card from the employer-sponsored or private health insurance plan under which they are covered.

Spenddown participants receive MediPlan cards only for periods when their spenddown has been met and they are actually eligible for Department payment for their medical expenses. Refer to Topic 113 for a more complete explanation of spenddown.

Temporary cards are explained in Topic 109.

108.1 MEDIPLAN CARD

Form HFS 469, MediPlan Card, is the identification card issued on a monthly basis by the Department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago), All Kids Assist or Moms and Babies.

In addition, the MediPlan card may be issued for a Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for Department consideration for payment of Medicare coinsurance and deductibles. In these instances, the MediPlan Card is clearly marked “QMB Only”.

MediPlan cards are printed on white paper with the State of Illinois seal printed in light blue.

108.2 ALL KIDS IDENTIFICATION CARD

Form HFS 469KC, All Kids Identification Card, is the identification card issued on a monthly basis by the Department to each person or family who is eligible under All Kids Share or All Kids Premium. All Kids cards are printed on canary yellow paper with the All Kids logo printed at the top.

108.3 IDENTIFICATION VERIFICATION

An individual who claims to be an eligible participant, but is unable to present a current and valid card, should be considered ineligible until proven otherwise. See Topic 113 for an explanation of the eligibility status of enrolled spenddown participants.

To assure proper identification of eligibility for a person who presents an identification card issued by the Department, either the MediPlan Card or All Kids Card, the provider should:

- Ask for some additional piece of identification to ensure that the person presenting the card is actually the same person listed on the card.
- Determine that the date of service is within the period eligibility printed on the card.
- Ensure that the card presented is a valid card. All valid MediPlan Cards are computer printed with the State of Illinois seal shown on the front in light blue. All valid All Kids Identification Cards are computer printed on yellow stock with the All Kids logo shown at the top. (See Topic 108.4 and Topic 108.5 for examples of the front and back of each card and messages they carry).

Cards that are questionable and that should be investigated include:

- Cards that have been altered in any manner;
- Cards containing any handwritten entries;
- MediPlan Cards without a State Seal or MediPlan Cards with a State Seal in any color other than light blue;
- All Kids Identification Cards that do not contain co-payment information;
- All Kids Identification Cards that do not have the All kids logo shown at the top;
- All Kids Identification Cards on other than yellow stock; or
- Cards that do not follow the format of the sample cards described in this Topic.

The identification card should be considered valid only if the participant is able to produce the complete card at the time services are rendered.

Providers may contact the FCRC for further verifications of questionable MediPlan Cards. Providers may verify a participant's eligibility via AVRS by calling the Provider Health Care Hotline 1-800-842-1461. Providers may contact the regional DCFS office for verification of eligibility of children served by DCFS. Providers may contact the Department's Central All Kids Unit for further verification of questionable (yellow) All Kids Cards.

Providers may also utilize the REV system for verification of either Medical Assistance of All Kids eligibility, restrictions or co-payments. See Topic 131.2 for an explanation of the REV system.

If a provider suspects fraud or abuse regarding the use of a MediPlan or All Kids Card, the provider should call the Fraud and Abuse Hotline, at 1-800-252-8903.

108.4 PRIMARY PORTION (FRONT) OF IDENTIFICATION CARDS

Reduced facsimiles of the primary portion (front) of the MediPlan Card and All Kids Card are provided on the next page. An explanation of the contents of the front portion of both cards is provided on the following pages. The item numbers that correspond to the explanations appear in small circles, for example

5

Reduced facsimile of the primary portion (front) of the MediPlan Card

1

2 Case ID Number
94 102 00 011111

3 Eligibility Period
09-01-2007 Through 09-30-2007
CASELOAD: Z99

4 YOUR NAME
123 MAIN STREET
ANYTOWN, IL 60000-1000

5

6

99999999 HFS 469 (R-4-06) 11-082302 IL 487-0234

Note: The seal of the state of Illinois appears in blue ink in the spot marked with a large X in a circle.

Reduced facsimile of the primary portion (front) of the AllKids Card

00000001

1

2 Case ID Number
94 180 00 W00000

3 Coverage Period
09-01-2007 Through 09-30-2007
CASELOAD 999

4 YOUR NAME
45 ANYPLACE
YOUR TOWN, IL 60000-1000

5

6

HFS 469KC (R-4-06) IL 478-0234

Note: the All Kids Card is printed on canary yellow paper.

FIELD OR ITEM

EXPLANATION

1

Control Area

This area is for state use only. It is separated from the remainder of the card by a thin broken line. On the MediPlan Card, the small control number that appears near the top of the card in this section is repeated on the back of the card. This area also contains a series of vertical lines, which may vary from card to card. The large control number near the bottom appears only on the front of the card.

2

Case ID Number

The case identification number identifies the specific case or family unit in which all participants listed on the card are included. The case identification number may be used by the provider as a reference when contacting the Department, the FCRC or the regional DCFS office. This number is not to be used by the provider on billing documents.

The number is composed of four distinct elements, each of which has a specific meaning:

Category - The first two digits indicate the program or category to which the participant belongs.

Persons in the following categories are eligible to receive covered services as listed in Topic 103.1.

00	90	98
01	91	
02	92	P2
03	93	P3
04	94	P4
06	96	P6

Exception: For a small number of persons in categories 91, 92 and 93, the MediPlan Card may have a designation of “QMB Only”. Service coverage for such persons is limited. For an explanation of this message, see the field titled “Program Coverage” in Topic 108.5.

Children who are wards of the Department of Children and Family Services (DCFS) or the Department of Corrections (DOC) are assigned case identification numbers beginning with **category 98**.

Persons eligible for the Transitional Assistance Program or the State Family and Children Assistance Program in the City of Chicago are assigned case identification numbers beginning with **category 07**. They are eligible to receive only the services listed in Topics 103.2 and 103.3. The only exception is that children 18 years of age or younger in these cases in the City of Chicago are eligible to receive the full scope of covered services as listed in Topic 103.1.

FCRC - The second set of digits identifies the office by which the participant's coverage is maintained.

DHS FCRCs outside Cook County are assigned numerical codes ranging from 010 through 115. Three downstate counties - Kane, Madison and St. Clair - are divided into districts and have more than one number assigned. Cook County is also divided into districts with each district office assigned a number in the 200 series.

FCRC codes 180 through 189, 196 and 220 indicate that the participant's case is managed directly by HFS' central unit.

FCRC codes 211, 313, 611, 612, 613, 711 and 713 indicate that the participant's case is managed by DCFS. Also see the exception described under the Group Number heading below.

Group Number - The third set of digits is used by the state to schedule administrative activities. It has no significance to providers. (**Exception:** Group 30, when shown after FCRC code 211, identifies cases managed by DOC.)

Basic Number -- The fourth and last set of digits, known as the basic number, identifies the specific case. Within each county, a unique basic number is assigned to each case. The basic number ranges from 6 to 8 digits and may contain both alphabetic characters and numerals.

3

**Eligibility/
Coverage
Period**

The dates listed in this section are the inclusive beginning and end dates of the coverage period documented by the card. Coverage for periods before or after the dates on the card can be verified following the instructions in Topic 108.3.

4

**Case Name
and
Address**

The case name appears in conjunction with the mailing address. It is the main identifier associated with the case identification number. The individual whose name appears as the case name is not eligible for medical services unless the name also is shown in the listing of "eligible persons" on

the back of the card. In instances in which a second individual, a bank, an agency or an institution has been designated as guardian, protective payee or representative payee, the applicable name and identifying initials will appear as part of the mailing address.

5 **Messages** A variety of explanatory messages may appear in this area. They include such subjects as allowable co-payments and managed care restrictions. Further information on the meaning and impact of each message can be found elsewhere in this handbook, in the Topic devoted to the subject of the message.

6 **Special Limitations** If there is a program coverage designation in the upper right shaded (black) area of the MediPlan Card, it will be “QMB ONLY”.

No other program coverages or coverage limitations are shown in the upper right area on the front of the MediPlan Card. Other limitations (if any) appear either below the name and address in the **Messages** area or on the back of the card immediately below the name of each eligible person.

All Kids Cards do not have coverage designations in the upper right area of the card.

On some but not all cards, a bar code appears immediately above the shaded area.

108.5 ELIGIBLE PERSONS PORTION (BACK) OF IDENTIFICATION CARDS

Reduced facsimiles of the eligible person’s portion (back) of the MediPlan Card and All Kids Card are provided on the next page. An explanation of the contents of the back of both cards is provided on the following pages. The item numbers that correspond to the explanations appear in small circles, for example

6

Reduced facsimile of the eligible persons portion (back) of the MediPlan Card

1	Eligibility Period 09-01-07 Through 09-30-07	Case ID Number 94 102 00 011111	00000001
2	YOUR NAME 123 MAIN STREET ANYTOWN IL		5
2	ONLY THE FOLLOWING PERSONS ARE ELIGIBLE:		
3	YOUR NAME	ID#:444444444	4
6		DOB: 04-01-51	6
6		TPL:	

TOTAL NUMBER OF ELIGBLE PERSONS: 1			
7			
<div style="border: 2px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">X</div>			
-Please see front of card for important information-			

Note: The seal of the State of Illinois appears in blue ink in the spot marked with a large X in a circle.

Reduced facsimile of the covered persons portion (back) of the All Kids Card

1	Coverage Period 09-01-07 Through 09-30-07	Case ID 94 180 00 W00000 Number	ADDRESS CHANGED? CALL 1-877-805-5312 1-866-468-7543 RIGHT AWAY (TTY: 1-877-204-1012)	00000001
2	YOUR NAME 45 ANYPLACE YOUR TOWN, IL			
ONLY THE FOLLOWING PERSONS ARE COVERED:				
3	ANY NAME	ID#: 123123123	4	
3	NICK NAME	ID#: 789789789	4	
4		DOB: 01/01/2000		
4		DOB: 03/03/2004		

TOTAL NUMBER OF ELIGBLE PERSONS: 2				
7				
ALL KIDS PREMIUM LEVEL 1				
-Please see front of card for important information-				

FIELD OR ITEM	EXPLANATION
<p>1 Items Repeated from the Front of the Card</p>	<p>The Eligibility/Coverage Period, Case ID Number and Case Name and Address that appear on the front of the card also appear in the three boxes on the back of the card. These items are explained in Topic 108.4. Also, if a message appears in the shaded box on the front of the MediPlan card, that same message appears in the shaded area on the back.</p>
<p>2 Name and Program Coverage Messages</p>	<p>The first column in this area shows the name of every covered participant in the case. The order of the name is first name, middle initial and last name. The name, exactly as shown on the card, of the person to whom services were rendered should be entered as the patient name on the provider's claim.</p> <p>On the MediPlan card, a Program Coverage Message will be shown immediately below the name of each covered person. One or more of the following program coverage messages will appear as appropriate to the individual:</p> <p>GENERAL ASSISTANCE - specific program limitations are applicable and are specified on the card.</p> <p>GA - NO HOSPITAL - this is a category 07 case and hospital services are not covered.</p> <p>QMB ONLY - the individual listed is eligible for coverage as Qualified Medicare Beneficiary (QMB), but is not eligible for Illinois Medical Assistance. The Department considers for payment only the deductible and coinsurance amounts on Medicare covered services. (This notation will also appear in the upper right shaded area on the front of the card.)</p> <p>QMB/MEDICAID - the individual is eligible to receive the full scope of covered services listed in Topic 103.1. This message indicates that the person is also eligible for coverage as a Qualified Medicare Beneficiary (QMB); therefore, Medicare is to be billed for covered services prior to billing the Department.</p> <p>MEDICAID - the individual is eligible to receive the full scope of covered services listed in Topic 103.1. If any restrictions to this are applicable, they are specified in the message area of the card.</p>

PRENATAL NO INPATIENT - the individual is participating in the Illinois Medical Assistance Presumptive Eligibility Program (MPE) and is covered for ambulatory prenatal care only. No inpatient or long term care services are authorized.

MANAGED CARE - the individual is assigned to a specific MCO. The name and telephone number of the MCO will be shown to the right of this message. When there is such a designation, no other medical provider is to provide non-emergency services, other than dental, optical and family planning services, without first contacting the MCO.

On the All Kids card, if a participant is enrolled in a managed care plan, the **Managed Care** message will appear immediately below the name of that participant. If no one in the family is enrolled in managed care, the name of each covered person is the only information that appears in this column.

3

Recipient Identification Number (RIN)

To the right of each covered person’s name is the unique, nine-digit Recipient Identification Number for that individual. Each number is valid for only one person. Because this identification number is used to verify eligibility, it is essential that the provider take extreme care when entering the number on the billing form. Use of incorrect numbers is a common cause of billing rejections.

It is imperative that the specific number for the patient to whom the medical service was rendered, be used on HFS billing forms and on Medicare billing forms if they are expected to electronically cross over to HFS.

4

Date of Birth

The individual’s complete birth date appears in the next column. Its form is month (two digits), day (two digits) and year (two digits).

5

Medicare Coverage

The next column to the right identifies Medicare coverage of the individual. An entry will appear in this column only if the participant has Medicare coverage. If the space in this column is blank, it indicates that neither DHS nor HFS is aware of Medicare eligibility. This does not eliminate the provider’s responsibility to inquire about such coverage. The codes which may appear in this column are listed below with the type of coverage:

<u>CODE</u>	<u>TYPE OF COVERAGE</u>
PART A	HOSPITAL INSURANCE
PART B	MEDICAL INSURANCE
PART AB	BOTH OF THE ABOVE

6

TPL

The last column of each line will identify, by code, known third party resources. Information entered here will refer to the Department's record of such resources. The TPL resource code will consist of a three-digit numeric code that may be prefixed with an alphabetic coverage code. The three-digit resource code identifies a specific health insurance company or union fund. The alpha coverage code, if present, indicates the extent of coverage provided by the resource.

EXAMPLE: A participant who is insured under a health plan by Aetna Life Insurance Company will have "001" printed in the TPL column of the MediPlan card. The addition of the prefix "A" (A001) will indicate the participant has a "comprehensive" health plan underwritten by Aetna.

For an explanation of the TPL codes which may appear on the MediPlan Card, refer to General Appendix 9, Third Party Liability Resource Codes.

The lack of a code in this space means that the Department is not aware of any TPL coverage. It does not eliminate the provider's responsibility to inquire about the possibility of such coverage.

7

**Total
Persons**

The total number of persons listed in this line should always match the number of individual participants listed above the line.

109 TEMPORARY IDENTIFICATION CARDS

A Temporary MediPlan or All Kids Card is valid for the covered medical services as listed in Topics 103.1, 103.2 or 103.3, depending on the category code in the Case ID Number. If specific information is applicable for an individual case or person, it will be reflected on the card.

Form HFS 1411, Temporary MediPlan Card, is issued by the FCRC or the central HFS office to participants who are in need of immediate medical services prior to the receipt of their MediPlan or All Kids Card. It is a multi-part light blue form, with red pre-printed control numbers on the front and an explanation of the contents of the form printed on the back. There are two versions of the form, which are identical except that one has the DHS logo and name at the top, and the other has the HFS logo and name at the top.

Form HFS 1411CF, Temporary MediPlan Card, is a computer generated temporary card but it is the same as Form HFS 1411 in its usage as it pertains to a medical provider. Form 1411CF is printed on 8 1/2" x 11" sheets of plain white paper. Please note that, for a Form 1411CF to be valid, it must contain an FCRC or HFS office embossed seal.

Form HFS 469D, Temporary MediPlan Card, is issued by the local office of the Department of Children and Family Services (DCFS) to wards that are in need of immediate medical services prior to the receipt of their MediPlan Card. It is the last page of a multipart form printed on paper with a distinctive blue pattern. It does not have an embossed seal.

Form HFS 469D may not contain the Recipient Identification Number (RIN). A DCFS toll free number (1-800-228-6533) is available which providers can access during normal business hours to obtain the RIN for billing purposes. The toll free number is also printed on the reverse side of the temporary card.

Temporary Cards can be valid for up to thirty days. Each card should be carefully viewed to be sure that services provided are within the eligibility period shown. If the date on which the service is rendered does not fall within this time period, the provider should follow the procedures described in Topic 100 to determine if eligibility existed on the date of service.

If a service is provided to a participant who presents Form HFS 1411CF or 469D the provider should photocopy the form to use, if needed, to rebill a rejected claim. If a service is provided to a participant who presents Form HFS 1411, the provider should detach one copy to use, if needed, to rebill a rejected claim. The appendices of Chapter 200 contain billing instructions when a Temporary Card is used to verify eligibility.

On the following pages are reduced facsimiles of the front and back of Form HFS 1411. The version that is shown contains the HFS logo and name. The DHS version of the form is identical except on the front, the Department of Human

Services logo and name appear on the top of the form. The back of Form HFS 1411 is identical, regardless of which Department's logo appears on the front.

Also shown are reduced facsimiles of Form HFS 1411CF and Form HFS 469D.

Illinois Department of Healthcare and Family Services

MEDICAL PROVIDERS AND CLIENTS
SEE REVERSE SIDE

TEMPORARY MEDIPLAN CARD

DATE ISSUED

ELIGIBILITY PERIOD FOR TEMPORARY MEDIPLAN CARD

SPLIT BILL DAY

ALL BILLS ON SPLIT BILL DAY REQUIRE FORM HFS 2432
CAT. LOCAL OFFICE GRP. BASIC

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

RESTRICTION CODES _____ CLIENT _____
 DATE _____ RESTR. CODE/TYPE _____
 PRIM. PROVIDER _____

HFS 1411 (R-3-95) IL478-0297

ONLY THE FOLLOWING PERSON ARE EIGIBLE

9990099

FIRST	CLIENT LAST	RECIPIENT NUMBER	BIRTHDATE MM/DD/YY	RD	CM	MEDICARE CODE	TPL CODE

TOTAL NUMBER OF ELIGIBLE PERSONS _____

9990099

REGULAR DOCTOR (RD) NAME AND PHONE NUMBER	
1.	
2.	
3.	
4.	

CASE MANAGER (CM) NAME AND PHONE NUMBER	
1.	
2.	
3.	
4.	

Reduced Facsimile of Back of Form HFS 1411

THIS CARD IS NOT VALID IF IT HAS BEEN ALTERED OR CHANGED IN ANY MANNER

NOTICE OF CLIENT – This card is not transferable. Use by person other than those named is illegal.

NOTICE OF DHS STAFF – All items are to be completed if applicable to the case. If not applicable, enter XXXX.

NOTICE TO MEDICAL PROVIDERS – Not all types of medical goods and services are covered by public assistance programs. If in doubt whether specific goods or services are authorized for person(s) listed, contact the appropriate central office of the Department of Healthcare and Family Services as indicated in your Medical Assistance Program Handbook. You should require adequate identification from the person(s) using this card to obtain medical goods or services.

The following information provided for each eligible person listed on the front of this card: full name, recipient number, birthdate, Medicare coverage and TPL indicators Part A and /or B indicators refer to Medicare coverage (view the Medicare Health Insurance Card to verify coverage and correct claim number). TPL indicators identify other known sources available for payment of Medicare expenses. Bill Medicare and TPL source **before** you bill the Department of Healthcare and Family Services. NOTE: Split Bill Day refers to the date the spend-down obligation was met.

Check the front of this card to see if persons are restricted to one or more of the following: limited services, a managed care program, a primary physician and/or a primary pharmacy.

INFORMATION/RESTRICTION MESSAGES

- | | |
|--|---|
| <p>1. Emergency services are permitted.</p> <p>2. All bills on split bill day ***MM-DD-YY require Form HFS 2432</p> <p>3. Persons age 17 and under are eligible for AFDC (04) medical coverage</p> <p>4. Identification only. This card is not good for any type of medical services</p> <p>5. Limited to GA (Category 07) Covered Services</p> <p>6. GA (Category 07) services only. Hospital services are not covered.</p> <p>7. Managed care enrollee(s). Services may require payment authorization</p> <p>8. The primary physician named on the card must provide or authorize the following services to the client named below on a non-emergent basis: physician, clinical, pharmaceutical, outpatient hospital, laboratory and podiatric. The primary pharmacy named on the card must provide or authorize all prescription drugs on a non-emergent basis.
Dr. John Smith
The Pill Box Pharmacy</p> <p>9. The primary physician named on the card must provide or authorize the following services on a non-emergent basis: physician, pharmaceutical, clinical, outpatient hospital, laboratory and podiatric.

Dr. John Smith</p> <p>10. The primary pharmacy named on the card must supply or authorize all prescription drugs.

The Pill Box Pharmacy</p> <p>11. The primary physician named on the card must provide or authorize the following services to the client named below on a non-emergent basis: physician, clinical, pharmaceutical, laboratory and podiatric. The primary pharmacy named on the card must provide or authorize all prescription drugs on a non-emergent basis.

Dr. John Smith
The Pill Box Pharmacy</p> | <p>12. The primary physician named on the card must provide or authorize the following services on a non-emergent basis: physician, pharmaceutical, clinical, laboratory and podiatric.
Dr. John Smith</p> <p>13. Covered services are limited to Medicare deductibles and coinsurance</p> <p>14. Services include Medicare deductible/coinsurance and Medicaid services.</p> <p>15. No inpatient or long term care services are authorized. MPE client.</p> <p>16. Organ Transplant Services are not covered.</p> <p>17. Long term care services are not covered.</p> <p>18. Medicaid services exclude long term care not covered under QMB.</p> <p>19. Long term care services are not covered through _____
Mo/YR</p> <p>20. Long term care services are not covered beginning _____
MO/YR</p> <p>21. LTC services are not covered for the month(s) of _____ through _____
MO/YR MO/YR</p> <p>22. Medicaid services excludes LTC not covered under QMB for _____ - _____ MO/YR
MO/YR</p> <p>23. Medicaid services excludes LTC not covered under QMB beginning _____
MO/YR</p> <p>24. Medicaid services excludes LTC not covered under QMB through _____
MO/YR</p> |
|--|---|

Reduced Facsimile of Form HFS 1411CF

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
TEMPORARY MEDIPLAN CARD

VALID ONLY WITH SEAL

IMAGINARY, JANE DOE
45 ANYPLACE ROAD
YOUR TOWN, IL 60000

CASE ID: 94-106-00-123456
ELIGIBILITY PERIOD: 12/21/1999 THROUGH 12/31/1999
DATE ISSUED: 12/21/1999 CASE LOAD: 237
TOTAL NUMBER OF ELIGIBLE PERSONS = 1

ONLY THE FOLLOWING PERSONS ARE ELIGIBLE:

JANE DOE IMAGINARY
MEDICAID ID#: 987654321 DOB: 09-26-1978

**** NO MORE PEOPLE ****

MESSAGES

NOTICE TO RECIPIENT: This card is NOT Transferable.
Use by persons other than those named is illegal.
This TEMPORARY CARD IS NOT VALID IF IT HAS BEEN
ALTERED OR CHANGED IN ANY MANNER
TERM:K409 DATE: 12/22/99 TIME: 15:34:42

FOR HFS USE ONLY
SERIAL NO: 246801357

HFS SECURITY CODE
335221774786916

HFS 141CF

Note: To be valid, this form must have a HFS or DHS embossed seal.

Reduced Facsimile of Form HFS 469D

MEDICAL PROVIDERS AND RECIPIENTS SEE REVERSE SIDE	STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES TEMPORARY MEDIPLAN CARD	MEDICAID
	WARD'S CASE I.D. NUMBER	<input type="text"/>
WARD'S NAME	ELIGIBILITY PERIOD	<input type="text"/>
<input type="text"/>		
LAST FIRST MI	WARD'S BIRTHDATE	RACE SEX
	<input type="text"/>	<input type="text"/> <input type="text"/>
SUBSTITUTE CARE PLACEMENT NAME		
<input type="text"/>		
LAST FIRST MI		
SUBSTITUTE CARE PLACEMENT ADDRESS		
<input type="text"/>		
STREET P.O. BOX R.R	AUTHORIZATION SIGNATURE	
<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY. STATE, CNTY, ZIPCODE		
TEMPORARY RECIPIENT I.D. NUMBER		ONLY VALID DURING ABOVE ELIGIBILITY PERIOD
HFS 469D (R-12-99) WARDS MEDICAL CARD		IL-478-1536

Note: This card is blue, with distinctive basket-weave pattern in background.

110 RECORD REQUIREMENTS

110.1 MAINTENANCE OF RECORDS

Providers are to maintain the following records:

- Any and all business records which may indicate financial arrangements between the provider and other providers in the program or other entities, or which are necessary to determine compliance with federal and State requirements, including, but not limited to:
 - business ledgers of all transactions;
 - records of all payments received, including cash;
 - records of all payments made, including cash;
 - corporate papers, including stock record books and minute books;
 - records of all arrangements and payments related in any way to the leasing of real estate or personal property, including any equipment;
 - records of all accounts receivable and payable; and
 - original signed billing certification forms for each voucher received (see Topic 130.5).
- Any and all professional records which relate to the quality of care given by the provider or which document the care for which payment is claimed, including, but not limited to:
 - medical records for applicants and participants in the Department's Medical Programs (copies of claims alone will not meet this requirement), including a record of ancillary services ordered as a result of medical care rendered by the provider; and
 - other professional records required to be maintained by applicable federal or State law or regulations.

The business and professional records required to be maintained are to be kept in accordance with accepted business and accounting practice and are to be legible.

Professional records documenting the history, diagnosis, treatment services, etc., of a Medical Assistance, All Kids, Transitional Assistance or State Family and Children Assistance patient are to be made available to other health care providers who are treating or serving the patient, without charge and in a timely manner, when authorized by the patient in writing.

110.2 RETENTION OF RECORDS

Business and professional records must be maintained for a period of not less than three years from the date of service or as otherwise provided by applicable State law, whichever period is longer, except that:

- if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved, and
- original signed billing certifications for every voucher received are to be retained not less than three years from the date of the voucher (see Topic 130.5).

110.3 AVAILABILITY OF RECORDS

All records required are to be available for inspection, audit and copying (including photocopying) by authorized Department personnel or designees during normal business hours. Such personnel or designees may include but are not limited to the Department's Office of Inspector General, representatives of the Medicaid Fraud Control Unit, law enforcement personnel, the Office of the Auditor General, and the federal Centers for Medicare and Medicaid Services (CMS). Such personnel or designees shall make all attempts to examine such records with minimum of disruption to the professional activities of the provider.

The provider's business and professional records for at least 12 previous calendar months are to be maintained available for inspection without prior notice by authorized Department personnel or designees on the premises of the provider. Department personnel shall make requests in writing to inspect records more than 12 months old at least two days in advance of the date they must be produced.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

111 PRIOR APPROVAL PROVISIONS

Prior approval is required for the provision of certain medical services/items in order for payment to be made by the Department. Services/items requiring prior approval are identified in Chapter 200 of the Handbook that pertains to that type of service. Providers are responsible for obtaining prior approval for services/items to be provided. Copies of the appropriate forms and instructions for use in requesting prior approval are included in the appendix of the appropriate provider Handbook.

An approved request does not guarantee payment. Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it remains the provider's responsibility to verify the patient's eligibility on the date of service and to confirm the patient's continuing need for the service.

In general, in order for prior approval to be granted, items or services must be appropriate to the patient's needs, necessary to avoid institutional care, and medically necessary to preserve health, alleviate sickness, or correct a handicapping condition.

The information that must be submitted with a prior approval request may include but is not limited:

- Patient's name
- Patient's Recipient Identification Number
- Patient's age, address, and whether or not the patient resides in a long term care facility.
- Identification of the practitioner prescribing or ordering the service/item
- Diagnosis or diagnoses
- Description of service/item
- Treatment plan
- How long the service/item will be needed
- Purchase or rental cost
- For transports, both pick up site and destination

The exact information required will depend on the item or service for which prior approval is being requested. Refer to the appropriate Chapter 200 for further details.

To the extent possible, the request should show how the service/item is expected to correct or help the condition, and why the requested treatment plan is better than any other plan commonly used to deal with similar diagnoses or conditions.

Anything unique to the medical condition or living arrangement affecting the choice of a recommended treatment plan or item should be explained. Approval is not transferable. When it is given, only the provider submitting the request may expect payment for the approved service/item.

The Department will not give prior approval for a service/item if a less expensive service/item is appropriate to meet the patient's needs. The Department will not approve purchase of equipment if the patient already has equipment which is adequate and sufficient to meet his/her medical needs.

Except for medical transportation requests, written notice of the disposition of requests for prior approval will be sent to the patient and to the provider. In the case of transportation requests, the DHS local office may advise the patient or provider orally at the time the prior approval decision is made. This will then be followed by a written approval sent to the transportation provider. The provider is responsible for retaining the written prior approval for audit purposes.

When a request is denied, the patient will be advised of his/her right to appeal the decision and to have a fair hearing. An appeal may not be made by the provider.

111.1 PRIOR APPROVALS OUTSIDE ORDINARY PROCESSING

The ordinary processing of a prior approval request for items such as, but not limited to, pharmaceuticals, durable medical equipment, prosthetics or disposable medical supplies may be bypassed if the service is needed to facilitate a hospital discharge or because of an unforeseen circumstance.

The provider supplying the item may contact the Department by telephone to provide information regarding the prior approval, including the date by which an authorization decision is needed and all other information necessary for completion of the prior authorization review. When it is necessary to provide an item outside of routine business hours, approval via telephone must be requested the next business day. If not, the request will be handled as a routine post approval request. Once an approval is given by telephone, no further evaluation of the request will be made. Requests for renewal of such an approval, if needed, will be considered within the ordinary processing procedures for prior approval requests. Refer to the appropriate Chapter 200 for detailed instructions on obtaining prior approvals.

111.2 APPROVAL AUTHORITY FOR PRIOR APPROVAL REQUEST

Listed below are the various Department sections to be contacted by providers. They are specified by provider type and/or services.

For durable medical equipment and supplies, occupational, physical and speech therapies, podiatric items and services, communication and prosthetic devices, or home health agency services, contact:

Illinois Department of Healthcare and Family Services
Prior Approval Unit
Post Office Box 19124
Springfield, Illinois 62794-9124
1-877-782-5565 select option 5 from the automated menu
FAX # (217) 524-0099

Prior approval requests may also be submitted electronically through a REV vendor. See Topic 131.2 for an explanation of the REV system.

For drugs not included in the Department Drug Manual and Refill-Too-Soon override requests, contact:

Illinois Department of Healthcare and Family Services
Pharmacy Unit
Post Office Box 19117
Springfield, Illinois 62794-9117
1-800-252-8942 or 1-877-782-5565

PHARMACIES ONLY – Automated Voice Response System (AVRS) Available 24 hours, 7 days a week, including holidays – 1-800-642-7588.

For dental services which require prior approval, contact:

Doral Dental Services
DDS of Illinois – Authorizations
1201 North Port Washington Road
Mequon, WI 53092-3376
1-888-281-2076

For extraordinary modes of transportation, for example, helicopters and fixed-wing airplanes, contact:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19116
Springfield, Illinois 62794-9116
1-877-782-5565
FAX (217) 524-7120 or (217) 524-4283

For approval of routine transportation within Illinois or to facilities normally utilized by Illinois residents, contact the patient's local FCRC.

Exception: For approval of routine transportation for All Kids Share and Premium Level 1 participants, contact the HFS Central All Kids unit at 1-877-805-5312. These cases can be identified by the 180 through 189 or 220 number in the Responsible Office portion of the case identification number. Refer to Topic 108.4 for further information or interpreting the case identification number.

For practitioners only, for any circumstances not outlined above, contact:

Illinois Department of Healthcare Family Services
Bureau of Comprehensive Health Services
P.O. Box 19115
Springfield, Illinois 62794-9115
1-877-782-5565
FAX # (217) 524-7120

Services which are not covered by the Illinois Medical Assistance Program may be available to DCFS wards through a prior approval process by the appropriate Regional Office of DCFS. Requests for prior approval for these services are to be

submitted on the appropriate HFS prior approval request form direct to the Regional Office through which the DCFS ward is being served.

For managed care enrollees, the MCO designated on the MediPlan or All Kids card should be contacted for prior authorization for all non-emergency services. Prior authorization for emergency services is not required for managed care enrollees, but MCO authorization for post-stabilization services is required. MCOs provide 24 hour access to health care professionals designated to provide authorization services. Providers must make two documented good faith efforts to contact the plan for authorization of post-stabilization services. The plan must pay for covered post stabilization services if the plan was not accessible to the provider or if authorization was not denied within 60 minutes. The provider must continue to try to contact the plan after post stabilization services are rendered.

112 SUBMITTAL OF CLAIMS

This Topic addresses general requirements for claims submitted directly to the Department for payment. Other or additional requirements may apply when claims are processed by a fiscal intermediary, for example, dental claims submitted to the Department's dental contractor. General instructions for claims that are covered in part by Medicare or other payors can be found in Topic 120. Instructions for paper claim preparation and submittal for specific service or provider types are included in the Chapter 200 series and its associated Appendices.

112.1 VALID BILLING CODES

For billing purposes, the Department requires that ICD-9-CM or upon implementation, ICD-10,-CM diagnosis codes be used in the "Diagnosis Code" area of the UB-04 and NIPS claims forms. On non- institutional claim forms, all levels of Healthcare Common Procedure Coding System (HCPCS) codes, including CPT procedure codes and nationally assigned Medicare procedure codes are recognized. HCPCS codes can also be used in the "Revenue Code" area of the UB-04, if indicated. In the "Procedure Code" area of UB-04, HCPCS must be used if a procedure code is required. NDC codes are used for drugs and some medical supplies.

Codes other than as described above will not be honored for billing purposes and payments made in error for such billings may be recouped.

112.2 TIME LIMITS FOR CLAIM SUBMITTAL

With the exception of those claims that are received by the Department and immediately returned to the provider as being unacceptable for processing, all claims received are assigned a unique Document Control number (DCN) and computer processed. The DCN consists of the date the claim was received by the Department (expressed as a Julian date) plus an individual number to identify the specific claim. A Julian Date Calendar is provided in General Appendix 4.

A claim will be considered for payment only if it is received by the Department no later than 12 months from the date on which services or items are provided. This time limit applies to both initial and resubmitted claims. Rebilled claims, as well as initial claims, received more than 12 months from the date of service will not be paid.

The action taken on each claim processed is reported to the provider on Form HFS 194-M-1, Remittance Advice. Providers should resubmit claims only if their claims fail to appear in the MEDI System thirty (30) days after submission to the Department. The provider should prepare a new original claim for submittal to the Department. It is the responsibility of the provider to assure that a claim is submitted timely.

Exception: Claims are generated by the Department of Long Term Care providers, using Form HFS 3402, LTC Pre-Payment Report. Discrepancies on such claims are not to be rebilled as described above. LTC providers should consult Chapter C-200 for instructions on resolving missing claims or discrepancies

Claims which are not submitted and received in compliance with the foregoing requirement will not be eligible for payment by the Department and the state shall have no liability for payment thereof.

112.3 REQUIREMENTS WHEN BILLING ELECTRONICALLY

In order for enrolled providers to submit claims electronically, they must have completed and the Department must have on file an Agreement for Participation (HFS 1413). The Provider Information Sheet produced by the Department displays a “Y” associated with the item labeled Agreement for Participation (AGR) when an agreement is on file with the Department.

Note that electronic submission of claims may be suspended during a period of time when the Department is performing an audit of the provider. If this occurs, the Department will notify the provider that he or she must submit paper claims and when electronic billing may be resumed.

112.31 Electronic Claims Capture (ECC)

Providers may submit all non-institutional claims other than pharmacy claims, as well as institutional claims billed on form UB-04, electronically through Recipient Eligibility Verification (REV) vendors and the Medical Electronic Data Interchange (MEDI) Internet site. The Department accepts non-institutional claims in the X-12 837 Professional standard, Version 5010 and institutional claims in the X-12 837 Institutional standard, Version 5010.

The Department has contracted with several REV vendors who will collect the claim data from providers and forward them to the Department in the proper format, acting as clearinghouses, if necessary. The REV vendors will make the necessary instructions for use of the appropriate electronic format available to providers. Each vendor may have different requirements for testing, pre-editing, reports, etc., and offer value added services. Providers should choose a vendor who best meets their needs. Information regarding REV vendors can be obtained from the Department’s Web site or by contacting the Department at 1-877-782-5565.

Electronic claims can be submitted to the Department through a REV vendor or MEDI.

All electronically submitted claims will be subject to the same edits and be reported on a Remittance Advice in the same manner as paper claims. The same requirements for claim submission, including verifying patient eligibility, billing known insurance carriers, and reporting TPL payments, exist as for paper claims. Electronic

claims have the advantage of being entered into the Department's claims processing system more quickly.

Claims that require an attachment as well as adjustments to paid claims cannot be submitted electronically at this time. They must continue to be submitted to the Department on paper billing forms.

Each Remittance Advice that reports electronically submitted claims will be accompanied by the form HFS 194-M-C, Billing Certification.

The provider who provided the services and submitted the claim for payment must review the Remittance Advice and attest to the accuracy of the information thereon by signing the Billing Certification.

The same signature requirements that apply to the signing of a paper claim, as described in Topic 112.41 apply to form HFS 194-M-C, Billing Certification. The signed form must be maintained in the provider's records for three years from the date of the Remittance Advice to which it relates or for the time period required by applicable federal and State laws, whichever is longer.

112.32 Electronic Claims Processing (ECP)

Electronic Claims Processing (ECP) is the system by which providers may submit claims for pharmacy services to the Department electronically. For claims submitted via ECP, only the National Council of Prescription Drugs Program (NCPDP) Version D.0 billing format is acceptable. Since this format is proprietary, providers must contact NCPDP to receive a copy of the format. NCPDP may be reached at (602) 957-9105 or via FAX at (602) 955-0749.

Three companies serve as transmitters for claims information from a pharmacy to the Department. The pharmacy may choose any one of the companies. They are as follows:

Company	Contact	Telephone Number
WebMD (Envoy Corp)	Help Desk	(800) 333-6869 Ext. 4001
WebMD (MedE America) Tech Rx	Client Services Department NDC Help Desk	(800) 433-4893 (800) 888-0412

All software created using the NCPDP formats must be tested and approved by the Department. Questions regarding ECP testing or to obtain a set of test conditions should be directed to the Bureau of Technical Support at (217) 524-7288.

112.4 REQUIREMENTS WHEN BILLING ON PAPER

112.41 Claims Preparation

To facilitate processing and to minimize chances for rejection or error in payment, it is recommended that claims be typewritten or computer printed. Refer to the Chapter 200 series and its Appendices for applicable guidelines

Claims must be legibly signed and dated in ink by the provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable.

An authorized representative may only be trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. Such a representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service.

It is mandatory that claims to the Department for services be submitted only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

112.42 Mailing of Claims

All claims with the exception of the UB-04 are to be mailed in the preaddressed envelopes supplied by the Department as specified in the Chapter 200 series and appendices. Any deviation from this requirement will delay payment. All other correspondence is to be mailed separately from claims, unless specified as a required attachment to a claim and addressed to the appropriate office as specified in the Chapter 200 series.

To expedite processing of claims, the following procedures should be used:

- review all forms for accuracy and completeness
- do not fold or mutilate claims
- do not staple, paper clip, or otherwise attach claims together
- mail as many claims as possible in one envelope
place claims in envelope with all pages facing in the same direction

112.43 Ordering of Claims Forms and Envelopes

HFS provides required billing forms (with the exception of UB-04 claim form), adjustment forms, prior approval request forms and various types of pre-addressed mailing envelopes for submission of claims to the Department.

A provider must request forms using Form HFS 1517, Provider Forms Request, and mail it to the preprinted address on the top of the request form. See General Appendix 10 for sample form HFS 1517 and instructions for their completion.

The provider should submit requests for forms or envelopes at least three weeks in advance of needing the material. The Department will not mail forms (except Form HFS 1517) in response to telephone requests. To obtain the appropriate claim form number and mailing envelope number, refer to Chapter 200 for the type of service being billed.

In order to receive a supply of forms, a billing service must supply (in addition to the name of the company and its mailing address) at least one HFS provider name and that provider's HFS provider number.

UB-04 claim forms are not provided by the Department. Providers must purchase them from private vendors.

112.5 CLAIM PROCEDURES FOR MEDICARE COVERED SERVICES

Charges for deductible and coinsurance amounts due for Medicare covered services are to be submitted to the Department only after adjudication by the Medicare carrier or intermediary.

Services billed to the Illinois Medicare Part B Carrier or Durable Medical Equipment Regional Carrier (DMERC) as first payor will be "crossed over" to the Department electronically for consideration for payment of coinsurance or deductibles or both by the Department. Paper claims should not be submitted directly to the Department when the Medicare Remittance Notice shows a message or code stating that the claim has been forwarded to the Illinois Department of Healthcare and Family Services.

Providers who bill other Medicare carriers or intermediaries should continue to bill the Department for the patient liability by submitting a claim containing the same information as the claim adjudicated by Medicare with a matched Medicare Remittance Notice attached. **Exception:** It is not necessary to attach a Medicare Remittance Notice to UB-04 claims; however, Medicare payment information must be reflected on the claim submitted to the Department.

A claim that has been totally rejected for payment by Medicare may be submitted for payment consideration only when the reason for nonpayment is either that:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claim by the Medicare carrier or intermediary.

For further information on the Department's payment policies for services to Medicare participants, refer to Topic 120.1. For detailed billing instructions on such claims, refer to Chapter 200.

112.6 CLAIMS PROCEDURES FOR RECIPIENT RESTRICTION PROGRAM (RRP) SERVICES

Claims for services to participants who have been restricted to a Primary Care Physician (PCP) or Pharmacy require no special forms or procedures as long as the services are provided by the Primary Care Physician or Pharmacy.

When restricted services are provided by the other providers, they require the written authorization of the PCP. Authorization is documented on a Form HFS 1662. A completed Form HFS 1662 must be attached to the claim(s) for restricted services. Form HFS 1662 may authorize one service date only. Therefore, the date of service on a claim(s) must be for the date specified on Form HFS 1662. Multiple services billed on a single claim form may be attached to a single (1) Form HFS 1662 provided that all dates of service are the same.

The Form HFS 1662 and the appropriate billing form are to be submitted to:

Illinois Department of Healthcare and Family Services
Post Office Box 19118
Springfield, IL 62794-9118

A supply of Form HFS 1662 may be obtained by contacting the Department by phone at 1-800-325-8823.

Billings for restricted types of care without Form HFS 1662 attached will be rejected. Rejection Code R29, "Recipient Services Restricted", or Rejection Code R30, "Care Not Authorized by Primary Physician," will appear on the Remittance Advice when claims are submitted for restricted services without an attached Form HFS 1662 completed by the Primary Care Physician or Primary Care Pharmacy.

These claims should be resubmitted to the address listed above only if one of the following is attached:

- A completed Form HFS 1662 from the PCP, authorizing the service(s) and date(s) of service.
- A copy of the participant's MediPlan Card or All Kids Card or Temporary Card if the RRP restriction message and the PCP designation were not printed on the card on the date(s) the service was rendered.

If neither of these is available, the claim should not be resubmitted as payment cannot be authorized.

113 SPENDDOWN

The spenddown program provides Medical Assistance to participants who would otherwise be ineligible because of income or assets or both which exceed the Department's standards.

113.1 SPENDDOWN EXPLAINED

Spenddown is similar in concept to a patient deductible in a private insurance plan, with three major exceptions:

1. The participant's spenddown obligation is determined on a monthly basis. (Deductibles in most insurance plans are determined on an annual basis.)
2. The amount of that monthly spenddown obligation is based upon the participant's income and assets. (Most insurance plans have a standard deductible regardless of patient income.)
3. When spenddown is met in the middle of a month, the decision as to which bills are the patient's responsibilities and which are the Department's is made chronologically based on date of service. (Most insurance plans base this decision on date of receipt of the bills.)

Although enrolled in the Medical Assistance program, spenddown participants do not automatically receive a MediPlan card each month. MediPlan Cards are only issued for the month (or portion thereof) for which participants have demonstrated that incurred or paid medical expenses equal the spenddown obligation by presenting medical bills and receipts to the FCRC. In the case of participants who have private insurance or other Third Party Liability (TPL) coverage, that portion of the medical bills and receipts which is paid by the TPL resource is not counted toward meeting the spenddown obligation.

Because the participant's eligibility can be determined only after he or she receives medical bills or receipts demonstrating that the spenddown obligation has been met, it is not unusual for the MediPlan Card to be issued several months after the month it covers.

If a provider accepts an individual as a Medicaid participant, all medical charges up to the amount of the spenddown obligation are the participant's responsibility.

For example:

- If a provider renders a service to a participant with a \$300 spenddown, and the Department's maximum rate for the service is \$275, and the private pay rate is \$350, the provider may only bill the participant for the \$300 spenddown amount. The provider may not bill the participant at the private pay level, or
- a participant's spenddown obligation is \$60, and he or she receives a medical service for which the provider charges \$80 but for which the Department's maximum rate is \$65. In this instance, the spenddown obligation would be satisfied by the provider's charges, the participant would be responsible for the

\$60 spenddown obligation and the Department would pay \$5. The participant could not be held responsible for the unpaid balance.

113.2 SPLIT-BILL DAY

Responsibility for bills on the day the spenddown obligation is met is often shared between the patient and the Department. This is referred to as “split-bill day”. The FCRC will notify the participant that spenddown has been met, which bills the participant is responsible for paying and which bills should be sent to the Department for payment. The FCRC will send Form HFS 2432, Split-Billing Transmittal, to the participant for each provider who is eligible for payment from the Department on the split-bill day. The participant is responsible for taking these forms to the medical provider. Upon request, the FCRC may send a Form HFS 2432 directly to the medical provider.

The Split-Billing Transmittal is issued only for those providers who are eligible for payment for services rendered on the split-bill day. No Form HFS 2432 will be issued for those bills which are totally the responsibility of the patient.

When any services are billed for a date that is determined to be a split-bill day, the Split-Billing Transmittal must be attached to the claim. Providers can determine the need for a Form HFS 2432 when billing by viewing the MediPlan Card. If there is a split-bill day, the MediPlan Card will contain a message regarding the need for Form HFS 2432 and identifying the service date affected.

If services were provided on the split-bill day and a Form HFS 2432 has not been received, the provider should determine whether or not one has been issued. This can be accomplished by viewing the notice sent to the participant or by contacting the FCRC. However, no billing should be submitted to the Department unless Form HFS 2432 has been received and attached to the Department claim. Unless a Form HFS 2432 has been received, the participant remains responsible for the charges incurred on the beginning date of eligibility.

Specific instructions for completing a claim form to which Form HFS 2432 is attached can be found in the Chapter 200 Appendices.

Reduced Facsimile of Form HFS 2432

State of Illinois
Department of Human Services

4 (3 Year)

SPLIT BILLING TRANSMITTAL FOR MANG SPENDDOWN PROGRAM

To:

This form is your authorization to bill the Illinois Department of Healthcare and Family Services for the services described below if you are currently eligible to participate in the Medical Assistance Program.

This is to certify that Recipient Name Recipient #

is eligible to receive medical assistance effective Date of Birth

Case Name: Last First Middle

Case I.D. Provider#: Cat. L.O. Grp. Basic

Description of Item/Service

Date of Service HFS Control Number of

Total Charge \$ Less Recipient Liability Amount \$

You are responsible for collecting the Recipient Liability Amount which is to be entered in the TPL and Deduction fields on a MMIS Invoice.

Attach this form to the back of your Medicaid or Medicare Crossover invoice and submit in a special envelope per Department Handbook instruction. Please consult your provider handbook for detailed billing instruction regarding the coding of Spenddown information on your particular invoice.

Local Office Administrator

Local Office

Date

Local Office Address Stamp



114 PATIENT COST-SHARING

Payments made by the Department to providers for services to eligible participants are considered payment in full. If a provider accepts the patient as a Medical Programs participant, the provider may not charge eligible participants for copayments, participation fees, deductibles, or any other form of patient cost-sharing, except as specifically allowed in this Topic or in Topic 113, Spenddown. In no other instance may any form of patient cost-sharing be charged to eligible participants for any covered services under any of the programs described in Topic 100 of this handbook.

Providers may not make arrangements to furnish more costly services or items than those covered by the Department on condition that patients supplement payments made by the Department.

114.1 ALL KIDS COPAYMENTS

For children covered by All Kids Share or All Kids Premium, copayments may be charged by health care professional whenever the services are performed in an office or home setting, except as listed below. No copayments may be charged for:

- Visits scheduled for well-baby care, well-child care, or age appropriate immunizations
- Visits in conjunction with the Early Intervention Program
- Visits to health care professional or hospitals made solely for radiology or laboratory services
- Speech therapy, occupational therapy, physical therapy and audiology
- Durable medical equipment or supplies
- Medical transportation
- Eyeglasses or corrective lenses
- Hospice services
- Long term care services
- Case management services
- Preventive or diagnostic services

Providers are not required to collect copayments.

Hospitals may charge copayments once per inpatient admission or outpatient encounter (including the emergency room).

No copayments may be charged for services provided to children in American Indian or Alaska Native families enrolled in All Kids Share or All Kids Premium. Providers should disregard copayment charge messages printed on All Kids Cards if a family declares American Indian or Alaska Native ancestry. Copayments cannot be charged for any child in that family. For families who declare American Indian or Alaska Native ancestry to the Department, a message will appear on the All Kids Cards indicating that no copayments may be charged.

Copayment information is printed on the front of the All Kids Identification Card. General Appendices 12 and 13 provides a detailed listing of services for which All Kids Share and All Kids Premium copayments may be charged and the amount of allowable copayments.

Copayments are capped at a maximum out of pocket expense for a family during a 12 month eligibility period. Families are responsible for collecting copayment receipts and submitting them to the Department once they have reached the cap. Upon determining that the copayment cap has been satisfied, the Department will:

- send a notice to the family stating that the copayment cap has been satisfied and the date satisfied,
- print a message that the copayment cap has been satisfied, and the date satisfied, on the monthly All Kids Identification Card, and
- update MEDI and REV to reflect that the copayment cap has been reached.

Providers have the option of either charging copayments, or not. The Department will not require providers to deliver services in instances when a co-payment is charged but is not paid. However, if the provider elects to charge co-payments, the provider will be responsible for refunding the family copayments they collect after the family has reached the copayment cap.

All Kids Share and Premium Level 1 copayments are in addition to any payments made by the Department. They are not to be shown on the claim submitted to the Department. If a provider enters the patient co-payment amount on the claim in error, as a patient contribution or a third-party payment, this will cause the Department's payment to be reduced.

114.2 COPAYMENTS FOR MEDICAL ASSISTANCE PROGRAMS

Participants in the Department's Medical Assistance Programs may be subject to a copayment as described below.

114.21 Fee-For-Service Copayments

A copayment may be charged to an adult participant in the Medical Assistance Program for each fee-for-service office visit to a physician, chiropractor, podiatrist or optometrist and for prescription drugs (legend drugs) received through a pharmacy, with certain exceptions. No provider of these services may deny service to a participant who is eligible for service on account of the participant's inability to pay the cost of the copayment. See Appendix 13 for specific codes subject to the co-payment. For further information, refer to 89 Ill. Adm. Code 140.402.

The Department will automatically deduct the copayment on applicable services from the payable amount and will report the deduction on the point-of-sale electronic billing system for pharmacies and on the remittance advice for all affected providers. When billing the Department, providers should continue to bill their usual and

customary charge and should not report the co-payment on the claim or electronic submission.

Reimbursement and copayments under the All Kids Share Plan and All Kids Premium Plan are not subject to this policy. See Topic 114.1 for an explanation of copayments under all Kids Share and premium.

114.22 Copayments for Inpatient Hospital Stays

A copayment may be charged to an eligible participant for certain inpatient hospital stays. The Department deducts such copayments when calculating the amount of its payment to the hospital. For further information, refer to 89 Ill. Adm. Code 148.190.

114.3 MEDICARE CO-INSURANCE AND DEDUCTIBLES

Medical Program participants may not be charged for Medicare co-insurance and deductibles, regardless of whether the Department pays all, some or none of the charges. Refer to Topic 120.12 for further details.

114.4 STATE RENAL DIALYSIS PROGRAM PARTICIPATION FEES

Participants in the State Renal Dialysis Program may be responsible for payment of a portion of the cost of covered dialysis services. This is referred to as the patient's monthly participation fee. It is determined by the Department on an annual basis. The Renal Dialysis Center is notified of the amount in writing, via a computer-generated Eligibility Report for Dialysis Patients.

The renal dialysis center may charge State Renal Dialysis Program patients for services up to the amount of the participation fee. Such charges will be automatically deducted from the patient's monthly dialysis claims submitted to the Department.

Other than the monthly participation fee, dialysis centers may not charge a State Renal Dialysis Program participant for any covered dialysis service for which a claim is submitted to the Department.

114.5 STATE HEMOPHILIA PROGRAM PARTICIPATION FEES

Participants in the State Hemophilia Program may be responsible for payment of a portion of the cost of covered services. This is referred to as the patient's annual participation fee. It is determined on an annual basis. Both the participant and the Hemophilia Center are notified of the amount in writing, via a letter from the Department.

Providers may charge State Hemophilia Program patients for covered services up to the amount of the participation fee. Such charges will be automatically deducted from the first bill or bills submitted to the Department.

Once the patient's annual participation fee has been met, a State Hemophilia Program participant may not be charged for any covered service for which a claim is submitted to the Department.

114.6 LONG TERM CARE FACILITY GROUP CARE CREDITS

Participants in the Department's Medical Programs who reside in Long Term Care (LTC) facilities may be responsible for payment toward the cost of covered services. This payment is referred to as the group care credit. It is determined for each resident on a monthly basis by the FCRC. The FCRC notifies the resident of the amount in writing. Refer to Topic C-212 in the Long Term Care Provider Handbook for an explanation of this process.

Facilities may charge residents for covered LTC services up to the maximum monthly payment rate established by the Department for those services, or their group care credit that month, whichever is less. Such charges will be automatically deducted from the amount that would otherwise be paid to the LTC facility by the Department.

Refer to Topic C-230 in the Long Term Care Provider Handbook for a listing of services covered by the Department's monthly payment to the facility.

114.7 HOSPICE PATIENT GROUP CARE CREDITS

When a hospice patient resides in a Long Term Care Facility, the hospice is responsible for payment of the LTC room and board charges. In this case, the patient's group care credit (if any) described in Topic 114.6 is automatically deducted from amount that would otherwise be paid to the hospice by the Department. Refer to Chapter K-200, Handbook for Hospice Providers for an explanation of this process.

120 OTHER PAYMENT SOURCES

The Illinois Department of Healthcare and Family Services is, by federal and State law, the payor of last resort. Payment can be made through the Department's Medical Programs only after all other known resources for payment, both private and governmental, have been explored and exhausted.

Examples of third party resources include Medicare, private health insurance, liability insurance, Worker's Compensation, Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), Veterans Administration benefits, Black Lung benefits, etc.

It is the responsibility of the provider to ascertain from each patient whether there is a third party resource that is available to pay for the services rendered. In an effort to aid providers in situations where a third party resource is known to the Department, the third party liability (TPL) resource coverage code is printed on the MediPlan or All Kids Card (see Topic 108); however, providers retain the responsibility for determining the status of a patient's eligibility for third party coverage and benefits prior to making charges to the Department.

In general, where identifiable third party resources exist, claims must be submitted to and adjudicated by the liable third party(ies) before the Department can consider a claim for payment. Refer to the Chapter 200 series for more specific instructions on billing services that may be covered by TPL.

The Department will make no payments in instances where the total payment to the provider from the third party resource(s) exceeds the established Department rate for the services provided.

120.1 MEDICARE

Medicare is the program authorized by Title XVIII of the Social Security Act which provides health insurance for most individuals age 65 or over, and for others regardless of age who meet disability requirements. Medicare benefits include hospitalization and related part (Part A) and supplementary medical services (Part B). The Medical Assistance Program complements and supplements Medicare program benefits to Medical Assistance participants by payment of deductible and coinsurance obligations in some instances and by providing coverage of additional medical services.

The MediPlan Card issued to participants (see Topic 108) indicates participant eligibility for Medicare to the extent that such eligibility is known to the Department.

120.11 Assignment of Benefits

Providers must accept assignment of Medicare benefits for services to Medicare eligible patients for which payment is sought from the Department, and so indicate by checking the appropriate box on the claim form.

In recognition of the difficulties encountered by providers in obtaining patient signatures, the Social Security Administration permits the Department to obtain participant signatures assigning payment to providers. The Department, through an interagency agreement with DHS, obtains signed assignment statements for all participants eligible for Medicare Part B benefits. Therefore, this section of the claim form can be completed indicating that the signature is on file with DHS. For more detailed instruction on completing this portion of a claim, refer to Chapter 200.

120.12 Medicare/Illinois Medical Assistance Program Relationship

If the MediPlan Card has a designation of QMB/MEDICAID, the individual is a Qualified, Medicare beneficiary (QMB) in addition to being an Illinois Medical Assistance (Medicaid) participant. Billings for services rendered are to be submitted to Medicare first. After Medicare adjudicates the claim, the Department's payment policies are as follows:

- The amount of Medicare payment is compared with the Department's maximum rate for the service. The Department will pay the deductible and coinsurance to the extent that such payment plus Medicare's payment does not result in an amount that exceeds the Department's maximum. If the payment from Medicare exceeds the Department's maximum rate for the service, the claim will appear on the Remittance Advice as approved, but no payment will be made.
- If there was a service on the bill to Medicare which is not covered by Medicare but is covered by the Medical Assistance program, the Department will pay (at Department rates) for the service.
- If a service is covered by Medicare but not by the Medical Assistance program, the Department will pay only the full amount of deductible and coinsurance.

If the MediPlan Card has designation of QMB ONLY, the Medicare beneficiary (QMB) is not eligible for Illinois Medical Assistance (Medicaid) services. The following payment policies apply:

- If a service is covered by Medicare but is not a covered service in the Medical Assistance program, the Department will pay the full amount of the deductible and coinsurance.
- If the Medicare service is also covered by the Medical Assistance program, the amount of Medicare payment is compared with the Department's maximum rate for the service. The Department will pay the deductible and coinsurance to the extent that such payment plus Medicare's payment does not result in an amount that exceeds the Department's maximum rate. If the payment from Medicare

exceeds the Department's maximum rate for the service, the claim will appear on the Remittance Advice as approved, but no payment will be made.

120.2 HEALTH INSURANCE

If the provider identifies health insurance that is not shown on the Department's medical card, or the insurance coverage shown on the card is no longer in force, notification is to be made to the address below.

Illinois Department of Healthcare and Family Services
Third Party Liability Section
P.O Box 19120
Springfield, Illinois 62794-9120
Telephone: (217) 524-2490
Fax: (217) 557-1174

120.3 PERSONAL INJURY CASES

It is the responsibility of the provider to notify the Department of any request from attorneys, insurance carriers, or participants for release of participant information.

Address requests pertaining to Cook County and out-of-state residents to:

Illinois Department of Healthcare and Family Services
Technical Recovery Unit
32 W. Randolph, 13th Floor
Chicago, Illinois 60601

Address requests for all other Illinois residents to:

Illinois Department of Healthcare and Family Services Technical Recovery Unit
2200 Churchill Road, Bldg. A
Springfield, Illinois 62702-3406

120.4 EXCEPTION FOR BILLING OTHER PAYMENT SOURCES FOR PREVENTIVE SERVICES FOR CHILDREN AND PREGNANT WOMEN

Physicians providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a client's private insurance carrier prior to billing the Department. Charges may be billed immediately to the Department. The Department will collect information regarding paid services and assume responsibility for the collection of the third party benefits.

In making the decision to bill the Department first, the provider should be cognizant of the possibility that the third party payor might reimburse the service at a higher rate than the Department, and that once payment is made by the Department, no additional billing to the other third party payor is permitted.

130 PAYMENT PROCESS

No attempt will be made by the Department to process unacceptable claim forms, such as unsigned claims, photocopies, forms other than those supplied or specifically approved by the Department, and illegible forms. Unacceptable forms will be returned to the provider for correct preparation and resubmittal.

Each service billed on a claim, whether it is an individual service or an all-inclusive or bundled package, is considered separately. One of three actions may be taken on a service billed: the service may be paid, rejected, or suspended for further review and final action.

130.1 REMITTANCE ADVICE

Form HFS 194-M-1, Remittance Advice, will be mailed separately to correspond with each warrant (check) issued to a provider. The Remittance Advice reports the status of claims and adjustments processed. See General Appendices 7 and 8 for an explanation of the information that will appear on the Remittance Advice.

130.2 PAYMENT

When payment is made, it will be made in accordance with Department standards and rate for the services(s) provided. Payment will be made by a State warrant (check) issued through the Office of the State Comptroller. Warrants and Remittance Advices are processed on the same day, but sent in separate mailings.

130.21 Designation of Payee

At the time of initial enrollment with the Department, a provider has the opportunity to designate the address to which warrants are to be sent. Certain types of providers also may designate alternate payees. Information specifying conditions under which a group practice or an institution may be designated as payee is included in materials issued to providers upon enrollment for participation. If a provider has more than one payee listed with the Department, each claim submitted for payment must specify the payee to which the warrant is to be mailed.

Changes in payee designation or addresses are to be submitted to the Department as they occur, to ensure that warrants are not sent to the wrong address or payee. Refer to Topic 201.4 for instructions on updating provider information on file with the Department.

Inasmuch as federal regulations prohibit assignment of Medical Assistance payments or payment by the Department to or through a factor, any arrangements where assignments have been made or power of attorney has been granted will have no effect on the Department's action with regard to delivery of warrants.

130.22 Electronic Funds Transfer

The Electronic Funds Transfer (EFT) option allows providers to have payments electronically deposited into their bank account. EFT must be requested by the payee, not by the provider. All payees receive a paper Remittance Advice for medical payments, even if they choose to receive payments electronically. EFT can be arranged by contacting the State Comptroller's Website at <http://www.oic.state.il.us/>

If provider does not wish to use EFT, hard copy or paper warrants will be mailed.

130.3 REJECTION OF CLAIMS

A service which cannot be paid due to errors that cannot be corrected by the Department will be rejected. The service will be identified on Form HFS 194-M-1, Remittance Advice, with the specific error(s) that rendered it unpayable.

A rejected service will be considered for payment only if all errors can be and are corrected and the corrected claim is resubmitted on timely basis. To be considered timely, the corrected claim must be received within 12 months of the date of service. Refer to the Error Code listing in General Appendix 5 for an explanation of the rejection reason(s) and the possible corrective action to be taken prior to contacting the Department.

It is important for the provider to verify all information on the claim, especially the participant eligibility. If a participant is not eligible for a date of service, the claim cannot be rebilled. Refer to Topic 108 for more information on verification of participant eligibility. Refer to Topic 131 for general information on assistance in resolving billing problems.

130.4 SUSPENSION OF CLAIMS

A service that cannot be adjudicated when first processed due to special handling requirements or the need for error correction by the Department will be temporarily suspended. If any service section on a claim form must be reviewed, the entire claim will be held in suspense pending adjudication of the suspended service section. Such a claim will be reported on the Remittance Advice as suspended.

Services listed as suspended are not to be rebilled. Suspended services will appear on a later Remittance Advice when they have been adjudicated as either paid or rejected.

130.5 BILLING CERTIFICATION

Paper claim forms all contain a certification statement, which the provider is required to sign. By signing the form, the provider is attesting to the accuracy of the information contained therein.

Electronic claims and claims created by the Department contain no such certification, nor is there a way for the provider to sign electronic claims at the time of submittal. Instead, the Department has instituted a post-payment certification as described below.

A copy of Form HFS 194-M-C, Billing Certification, accompanies each remittance advice which contains an electronically submitted paid service or a service paid as a result of a claim created by the Department.

It is the responsibility of the provider who provided the service and submitted the claim for payment to review the Remittance Advice and sign the Billing Certification form attesting the accuracy of the information therein.

The same signature requirements that apply to the signing of a paper claim, as described in Topic 112.41, apply to Form HFS 194-M-C. The signed Billing Certification form must be maintained in the provider's records for three years from the voucher date to which it relates or for the time period required by applicable federal and State laws, whichever is longer.

131 BILLING INQUIRY PROCESS

Situations will arise when a provider finds it necessary to contact the Department regarding claims. Providers are reminded to first check Chapter 200 of the applicable provider handbook to ensure that proper billing procedures have been followed.

The Department is committed to giving providers options in the methods by which they obtain information from the Department. Providers should evaluate the available options and choose the method that best meets their needs.

131.1 PHONE AND MAIL INQUIRES

The Department has billing consultants to assist providers in resolving billing issues.

The provider should have the following information ready prior to contacting a consultant for a billing inquiry:

- The patient's name and Recipient Identification Number
- The provider's name, Illinois Medical Assistance provider number and NPI
- Type of claim
- Date of service
- Voucher and Document Control Number, if the claim has already been submitted and reported on a Remittance Advice.

Addresses and phone numbers of Department contacts for various subjects or specific provider types are listed following the Table of Contacts at the front of Chapter 100.

Written inquiries are to be mailed separately from claims. They are not to be mailed in the preaddressed envelopes provided by the Department for mailing claims and other specific forms.

131.2 RECIPIENT ELIGIBILITY VERIFICATION (REV) SYSTEM

The Recipient Eligibility Verification (REV) system is an interactive electronic system. REV allows providers to:

- verify a participant's eligibility
- submit claims electronically
- check the status of claims in processing
- determine which claims have been paid and the amount paid
- determine which claims have rejected and the reason for rejection
- download batches of claim information

Durable Medical Equipment (DME) providers can electronically submit prior approval requests through the REV system. Also, Long Term Care (LTC) providers can use the REV system to electronically transmit bed reserve information, discharge information and Medicare payment status.

Participant information available through the REV system includes but is not limited to:

- eligibility for the Medical Assistance Program
- eligibility for All Kids
- eligibility for the Transitional Assistance Program and the State Family and Children Assistance program (City of Chicago)
- MCO enrollment
- Recipient Restriction Program (RRP) status
- participant Medicare coverage
- participant health insurance (TPL) coverage

Providers can access the REV system through vendors who are independent contractors who have agreements with the Department to provide this service. REV vendors provide this access by various methods, including:

- standardized software for use on existing PCs
- point-of-service devices
- custom programming of a provider's existing computer system to accept and transmit the Department's data

A listing of the current REV vendors is available on the Department's Web site at <http://www.hfs.illinois.gov/rev/>

All current REV vendors also act as clearinghouses for other public and private payors. In this role, REV vendors offer services beyond those related to the Department's programs. For example, these vendors may offer general computer accounting support, preliminary claim editing, accounts receivable posting, and claims submittal to various third party payors. Providers pay the REV vendors for whatever mix and volume of services are selected.

Providers are encouraged to contact all vendors on the list to determine which vendor will best meet the provider's needs. Providers should consider whether the provider's computer will be able to access a vendor's system. Additionally, providers should check the vendor's charges for use of the system and determine whether there are services other than those listed above which the REV vendor offers.

132 ADJUSTMENTS

When the Department reports an incorrect payment on Form HFS 194-M-1, Remittance Advice, the error is corrected and supplemental payments or recoveries are made via an adjustment process. This ensures that Department's claims history files reflect the corrected information.

If the error is due to a computer problem in the Department's data system, the Department may initiate the adjustments. If this occurs, the adjustments will be reflected on a remittance advice and providers will need to take no adjustment action.

In all other instances, the provider must take action to ensure that the payment is corrected.

132.1 PHARMACY ADJUSTMENTS

Pharmacy services paid electronically may be adjusted electronically via the Department's point of sale system, using the appropriate National Council of Prescription Drug Programs (NCPDP) protocol. Services requiring adjustment that cannot be submitted electronically must be submitted on paper (HFS 1410) as a void transaction. The void transaction may be followed by the submission of a new invoice reflecting the correct claim information.

Pharmacy services submitted on paper claims must be adjusted using the process described in Topic 132.3

132.2 LONG TERM CARE (LTC) FACILITY ADJUSTMENTS

LTC facilities do not complete adjustment forms for incorrect payments. The Department initiates adjustments on a monthly basis to reflect corrected or changed information that may alter payment amounts. LTC facilities should refer to Topic C-263 of the Handbook for Nursing Facilities for a description of the adjustment system

Exception: If a LTC facility bills the Department directly for ancillary services, such as supplemental oxygen, and is paid an incorrect amount, such claims must be adjusted using the process described in Topic 132.3.

LTC facilities are responsible for immediately reporting to DHS or to HFS any corrections or changes in information that may affect payments. This includes but is not limited to resident death, discharge or changes in income.

132.3 ALL OTHER ADJUSTMENTS

Adjustment can only be made on paid claims. If a provider becomes aware that a claim has been submitted that will require an adjustment, no corrective action can be taken until the claim is adjudicated and appears on a Remittance Advice. As soon as the claim has been reported as a paid claim on a Remittance Advice, the provider

should submit an Adjustment form to correct the payment. Copies of Adjustment forms and instruction for their completion are provided in General Appendix 6.

133 REFUNDS

Although the Adjustment process in Topic 132 should generally be used whenever incorrect payment has occurred, there may be instances in which a provider considers it necessary to refund an overpayment to the Department.

To ensure that a refund or returned check is processed accurately and that the Department's records are adjusted appropriately, special care should be taken to ensure that correct and sufficient information is provided. For all types of providers other than Long Term Care facilities, if questions arise about the refund process, if the required documentation is not available or if the process described below does not seem to fit the situation requiring the refund, the provider should contact a billing consultant at 1-877-782-5565. LTC providers should contact the Bureau of Long Term Care at 217-782-0545 for instructions in any situation requiring a refund.

Procedure: With the refund check, the provider should submit a copy of the appropriate Adjustment form. Refer to General Appendix 6 for instructions on completing Adjustment forms. The provider should also submit a copy of the Department-generated Remittance Advice which was received with the incorrect payment or overpayment. The Remittance Advice should be marked to clearly indicate which payments are being refunded. Following these instructions will ensure that the Department has all of the information necessary for processing the refund and adjusting the Department's claims history files.

The provider must ensure that the total of all the individual service adjustments equals the refund check amount. Verification of the Department's receipt of the refund and processing of the adjustments will be reported on a future Remittance Advice.

When a refund is made via a check written on the provider's own bank account, the check should be made payable to the Illinois Department of Healthcare and Family Services. The provider should not mix payment refunds for various provider types on one check, i.e., hospital and non-institutional services. Separate refund checks are to be submitted because the refunds will be processed by the Department in two separate refund systems

Refund checks for services billed on the UB-04 should be sent to the following address:

Illinois Department of Healthcare and Family Services
Hospital Adjustment Unit
P.O. Box 19128
Springfield, Illinois 62793-9128
Telephone: 1-877-782-5565

Pharmacy refund checks should be sent to the following address:

Illinois Department of Healthcare and Family Services
Drug Unit
P.O. Box 19117
Springfield, Illinois 62794-9117
Telephone: 1-877-782-5565

Non-Institutional Provider refund checks should be sent to the following address:

Illinois Department of Healthcare and Family Services
Adjustment Unit
P.O. Box 19101
Springfield, Illinois 62793-9101
Telephone: 217-524-4597

Third Party Liability (TPL) refund checks should be sent to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Collections, Third Party Liability
P.O. Box 19140
Springfield, Illinois 62794-9140
Telephone: 217-785-1753

134 AUDITS

All services for which claims are submitted to the Department are subject to audit. Audits are an important and necessary part of the Department's monitoring of health care facilities and services, as required by the federal and State law. Providers are selected for routine audit by a random sampling of billings processed and by other criteria determined by the Department. The initiation of audit proceedings should not be construed as an accusation of any wrongdoing on the part of the provider.

During an audit, the provider shall furnish to the Department, or to its authorized representative, pertinent information regarding claims for payment. Should an audit reveal that incorrect payments were made, or that the provider's records do not support the payments that were made, the provider shall make restitution.

The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under this procedure, the Department selects a statistically valid sample of the case for which the provider received payment for the audit period in question and audits the provider's records for those cases. All incorrect payments determined by an audit of the cases in the sample are then totaled and extrapolated to the entire universe of cases for which the provider has been paid during the audit period. Where sampling techniques are specific to the type of provider or claim being audited, additional details will be provided in Chapter 200.

The Department will recover all overpayments and take other action as appropriate. This may include seeking the termination of providers, in accordance with 89 Illinois Administrative Code, Part 104, Subpart C. For a more complete description of the recoupment process, refer to Topic 135.

135 RECOUPMENT RESULTING FROM AUDITS

The Department will recover payments when it is verified that overpayments have been made to a provider due to improper billing practices. The determination of overpayment will be based on Administrative Rules and Department policy and procedures as stated in the applicable Handbooks, or as evidence by statistical data on program utilization compiled from claims paid.

The provider will be notified in writing of the nature of any discrepancies, the method of computing the dollar amount which is to be refunded, and any further actions which the Department may take in the matter.

If the Department's findings were based on sampling and extrapolation, the provider may present evidence to the review coordinator to show that the sample used by the Department was invalid and, therefore, cannot be used to project overpayments identified in the sample to total billings for the audit period.

If the Department does not concur with the provider's position on the audit results, the Department's audit results stand. The provider receives written notification of the finding. If the provider remains in disagreement with the Department actions with respect to the audit, he or she may, within 10 days of receipt of the written notification, submit a request for a hearing. The notification specifies to whom the request for a hearing must be submitted.

The Department will notify the provider in writing of the date, time, and place of the review hearing. See 89 Illinois Administrative Code, Part 104, Subpart C, for complete details of the hearing process.

The provider may conduct an audit of 100% medical records of payments received during the audit period and present the results of such an audit at the hearing. Any such audit should demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with the regulations, provider Handbooks, and other written requirements of the Department. The provider should be prepared to submit supporting documentation to demonstrate the compliance.

136 FRAUD IN THE DEPARTMENT'S MEDICAL PROGRAMS

Providers are expected to obey all laws, civil and criminal, State and federal regulations, and Department policies pertaining to delivery of and payment for health care. The Department actively monitors all claims for payments to identify suspicious activities.

Providers suspected of fraud shall be criminally investigated and, when appropriate, prosecuted in state or federal court.

Providers suspected of fraud or abuse shall be reviewed to determine the propriety of continuing their participation in the Department's Medical Programs

The Department may suspend payments to providers indicted for health care fraud during the pendency of the indictment.

For purposes of participation in the Department's Medical Program, the Department defines fraud and abuse in the following manner:

Fraud: Knowing and willful deception or misrepresentation, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Abuse: A manner of operation that results in excessive or unreasonable costs to the Department's Medical Programs.

Title XIX of the Social Security Act, under which the Medical Assistance Program is administered, provides federal penalties for fraudulent acts and false reporting.

Providers are subject to State and federal laws pertaining to penalties for vendor fraud and kickbacks (305 ILCS 5/8A-3).

Program participants, providers or other individuals who have information regarding possible fraud or abuse should call the Fraud and Abuse Hotline, at 1-800-252-8903.

140 ADVANCE DIRECTIVES

An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of such care when the individual who executed the advance directive is incapacitated.

Under Illinois law, competent adults have the right to make decisions regarding their health care. The courts of this State have recognized that this right should not be lost when a person becomes unable to make his or her own decisions. Therefore, people have the right to accept or refuse any medical treatment, including life-sustaining treatment. In order to enable them to make these decisions, patients have the right to be adequately informed about their medical condition, treatment alternatives, likely risks and benefits of each alternative and possible consequences.

The law requires that patients be informed of the advance directives available to help assure that their wishes are carried out even when they are no longer capable of making or communicating their decisions. Every patient has the right to choose whether or not he or she wants to execute an advance directive.

Certain providers participating in the Medical Assistance Program must maintain written policies, procedures and materials concerning advance directives and give written information to all adults concerning their rights under State law to make decisions about their medical care.

Providers of Hospital, Long Term Care, Home Health Care, Personal Care, Hospice and Managed Care Organization (MCO) services must:

1. provide written information to all adult individuals concerning their rights under State law to:
 - make decisions concerning their medical care;
 - accept or refuse medical or surgical treatment; and
 - formulate advance directives, e.g., a living will or durable power of attorney for health care;
2. document in the individual's medical records whether or not the individual has executed an advance directive;
3. not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
4. ensure compliance with requirements of State law; and
5. provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Providers are responsible for furnishing written information to all adult individuals at the time specified below:

- Hospitals – at the time an individual is admitted as an inpatient;
- Long Term Care facilities – when the individual is admitted as a resident;
- Home Health care or personal care service providers – before the individual comes under the care of the provider;
- Hospice program – at the time of initial receipt of hospice care by the individual from the program; and
- Managed Care Organizations – at the time of enrollment of the individual with the organization.

An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether they have executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with State law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once the patient is no longer incapacitated.

When the patient or a relative, surrogate or other concerned or related individual presents the facility with a copy of the individual's advance directive, the facility must comply with the advance directive including recognition of the power of attorney, to the extent allowed under State law, unless the provider cannot as a matter of conscience implement such advance directive. If the provider cannot implement the advance direct, he or she must tell the patient or the patient's appropriate representative so that the patient can transfer to another provider. Absent contrary State law, if no one comes forward with a previously executed advance directive and the patients is incapacitated or otherwise unable to receive information or articulate whether they have executed an advance directive, the facility must note that the individuals was not able to receive information and was unable to communicate whether an advance directive existed.