

029 Ambulatory Services (Physical Rehabilitation)

Hospitals meeting certification standards set by the Department of Human Services, Division of Addiction Services Administration (DASA), may enroll for the following category of service:

035 Sub-acute Alcoholism and Other Drug Abuse Treatment - (see Topic H-279).

=H-201.12 Fee-for-Service Categories of Service

Effective May 16, 2011

Certain services provided in the hospital outpatient and clinic setting are subject to the fee-for-service payment methodology. These services are not billable on the institutional claim format. For these services, hospitals will be required to conform to the policies and billing procedures in effect for other non-hospital providers of services.

Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting.

The standard fee-for-service categories of service assigned are:

COS Service Definition

001 Physician Services – Effective with dates of service beginning July 1, 2008, hospitals may no longer bill fee-for-service for the professional services of salaried physicians and APNs in the outpatient setting. These claims for professional services must be billed under the name and NPI of the practitioner who rendered the service.

Hospitals may bill fee-for-service for those services described in the Handbook for Practitioner Services, Topic A-202.13.

- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services
- 014 Audiology Services
- 017 Anesthesia Services
- 030 Healthy Kids Services

- 040 Pharmacy Services (Drug and OTC)
- 041 Medical Equipment /Prosthetic Devices
- 048 Medical Supplies

H-201.13 Services Requiring Special Enrollment

A hospital pharmacy must enroll separately as a pharmacy provider to bill on a fee-for-service basis for services provided to a patient in:

1. A specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program;
2. A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility;
3. The outpatient setting when the services provided are not unique to the hospital setting (are not hospital APL-billable).

A hospital pharmacy that provides pharmaceutical services and supplies for inpatients, outpatient clinic patients and emergency room patients of the hospital may not enroll as a participating pharmacy unless licensed to provide pharmaceutical services to the general public (Division 5 license).

Drugs dispensed for treatment and/or diagnostic purposes during an inpatient stay or along with an APL procedure are included in the per diem or per discharge all-inclusive rate and no separate charge may be made.

A hospital that owns and operates medical transportation vehicles as a separate entity (for example, a private corporation) must enroll as a medical transportation provider under the appropriate provider type.

A hospital that owns and operates medical transportation vehicles that are included as a cost center of the hospital is required to enroll as a medical transportation provider under Provider Type 74, Hospital-Based Transportation. A hospital may not submit a separate claim for transportation services provided to persons admitted as inpatients, since the department pays an all-inclusive rate for per diem reimbursed hospitals or a per discharge rate for DRG reimbursed hospitals for inpatient services.

Refer to the Handbook for Medical Transportation Providers for further information.

Hospitals with a home health program must enroll the agency separately as a home health agency. Refer to the Handbook for Home Health Agencies for more information.

- g. The patient was advised that the sterilization will not be performed for at least 30 days, except in cases of premature deliveries or emergency abdominal surgery as indicated above.
2. Suitable arrangements were made to ensure that the information specified in (1) (a) through (g) was effectively communicated to any patient who is blind, deaf, or otherwise handicapped;
3. An interpreter was provided if the patient to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;
4. The patient to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;
5. The consent form requirements specified below were met; and
6. Any additional requirements of state or local law for obtaining consent, except a requirement for spousal consent, were followed.

Informed consent may not be obtained while the individual to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

The patient's written consent for sterilization must be obtained on Form HFS 2189 (Consent Form). All appropriate sections of the form are to be completed. See the department's Web site for a facsimile of [Form HFS 2189](#), and instructions for completion. **The HFS 2189 must be attached to the UB-04 billing form when charges are submitted.**

H-254.6 Abortion Services

Charges for an abortion and associated hospital services are covered services in the Illinois Medical Assistance Program only when the mother's life is endangered, to end pregnancies resulting from rape or incest, or if necessary to protect a woman's health.

Form HFS 2390, Abortion Payment Application, must be completed by a licensed physician certifying that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term; or certifying that the patient reported that the pregnancy was the result of rape or incest; or certifying that the abortion is necessary to protect a woman's health. See the department's Web site for a facsimile of [Form HFS 2390](#).

A copy of the completed HFS 2390, Abortion Payment Application, must be attached to the UB-04 claim form when charges are submitted. The claim must contain the appropriate Condition Code to reflect the reason the abortion was performed. Refer to the UB-04 Data Specifications Manual for the appropriate Condition Codes relating to the limited abortion circumstances above.

=H-254.7 Claims for Illinois Department of Corrections (IDOC) and Illinois Department of Juvenile Justice (IDJJ) Inmates

Effective May 16, 2011

All current and future inmates will be assigned a case number. Inmates who qualify for Medicaid will be assigned the applicable Category of Assistance. Inmates who do not qualify for Medicaid will be given a special eligibility segment designating them as having “Department of Corrections Eligibility.” **Responsible Office Number 195 within the case identification number will designate the patient as an IDOC or IDJJ inmate.** The responsible Office Number appears as the second set of numeric digits in the case identification number.

When an inmate presents at a hospital for services, an IDOC/IDJJ representative must accompany the inmate. The representative may give the hospital the recipient identification number for the inmate, if one has already been assigned, for the hospital to use when billing HFS. IDOC/IDJJ inmates are not issued regular medical cards and providers **should not** complete an application for medical assistance for IDOC/IDJJ inmates.

The message, “Eligible for Limited IDOC Hospital Benefit Package,” now appears in the Medicaid Recipient Eligibility Verification (REV) System; the Medical Electronic Data Interchange, Internet Electronic Claims (MEDI/IEC) System; and the Automated Voice Response System (AVRS). After checking eligibility through one of the verification systems listed above, hospitals may submit their bills.

In the event that the above message does not appear for an inmate, **please call HFS at 217-782-3541 for assistance.**

The “Eligible for Limited IDOC Hospital Benefit Package” message only extends medical coverage to inmates who are in custody of IDOC/IDJJ at the time services are rendered. **The IDOC/IDJJ special eligibility segment is considered valid only if an IDOC/IDJJ representative accompanies the person to the hospital.**

In the event that an IDOC/IDJJ representative does not accompany an inmate but the above message appears in the eligibility verification system, hospital providers are to consider the person as private-pay or self-pay and can complete an application for assistance on their behalf. Paroled or discharged inmates whose eligibility has not been updated are not the responsibility of HFS.

All services provided by an enrolled hospital provider, those reimbursed as institutional services and those reimbursed as fee-for-service, must be billed directly to HFS.

Effective with dates of service on and after May 16, 2011, individual practitioners who submit claims for professional services rendered in the hospital inpatient, outpatient, and emergency room settings must also submit inmates' claims directly to HFS under the practitioner's name and NPI.

H-260 Payment Process

H-260.1 Charges

Charges for inpatient and outpatient services must be submitted to the department on a UB-04 claim form or in the X12 837 Institutional claim format. Refer to Appendix H-2 for order information regarding the UB-04 Data Specifications Manual and an updated list of field requirements for the UB-04 claim format.

To be paid for services, all claims, including claims that are re-billed, must be received within one (1) year of the date of service. The department must receive a claim after disposition by Medicare, or its fiscal intermediary, no later than twenty-four (24) months from the date of service.

Charges billed to the department must be the provider's usual and customary charge billed to the general public for the same service. Providers may only bill the department after the service has been provided.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

=H-260.11 Inpatient Charges for MCO Patients Whose Coverage Begins or Ends During the Inpatient Stay

Effective October 1, 2011

- **MCO Coverage Beginning During the Inpatient Stay**

Hospital stays reimbursed on a DRG basis: If an MCO enrollee is receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment, the MCO will assume no liability for the stay.

Hospital stays reimbursed on a per diem basis: For hospital stays reimbursed on a per diem basis, the MCO's liability will begin on the effective date of enrollment.

- **MCO Coverage Ending During the Inpatient Stay**

Hospital stays reimbursed on a DRG basis: For hospital stays reimbursed by DRG, the MCO will be liable for payment for any inpatient medical care or treatment provided to a patient whose discharge date is after the effective date of disenrollment.

Hospital stays reimbursed on a per diem basis: For hospital stays reimbursed on a per diem basis, the MCO will be liable for payment for any medical care or treatment provided to a patient until the effective date of disenrollment.

H-260.2 Claim Preparation and Submittal

General policy and procedures for claim submittal are provided in Chapter 100, Topic 112. Additional specific policy and procedure pertinent to institutional claims vary based on the patient's eligibility for Medicare benefits. Appendix H-2 contains specific billing instructions for providers.

Inpatient claims for services rendered and reimbursed under the DRG payment methodology cannot be split. They must be billed admission through discharge.

Claims are to be submitted as soon as possible after discharge, but only after third party resources have been billed. As the department is the payer of last resort, providers are to bill any known third party first. If at the end of 30 days from the date of the TPL billing, no response has been received, or if a response has been received advising of the amount of the TPL payment, the provider may bill the department in accordance with instructions in Appendix H-2. **This excludes claims that are pending Medicare adjudication.** The department's TPL status codes are identified in the billing requirements in Appendix H-2.

In instances where the insurance company pays the patient directly and the hospital has not received payment from the patient, the hospital must indicate the insurance information on the claim and show TPL Status Code 07 (Payment Pending) when submitting the claim for payment to the department.

To assist the department in identifying hospital claims resulting from an accident where a third party may be liable for damages, the hospital must indicate the Accident Related Code and date as appropriate. Refer to the UB-04 Data Specifications Manual for further instructions.

H-260.21 Interim Claims

Claims for inpatient services rendered and paid by the per diem reimbursement methodology cannot be split unless the stay exceeds 30 days or unless the patient is transferred to another facility or category of service. **All other claims must be submitted from admission to discharge.**

Following are exceptions for which separate claims may be submitted:

1. Two admit through discharge claims must be submitted when a patient is admitted for one category of inpatient services and is transferred within the hospital for the receipt of inpatient services in a different category. For example, if the patient is admitted for general inpatient services and subsequently requires inpatient psychiatric services, one admit through discharge claim must be submitted for each category of service;

Billing Scenario 6 Medicare Part A Exhaust During Inpatient Stay

The patient has Medicare Part A and B. He was admitted to the hospital on March 10, 20XX and was discharged on June 24, 20XX. His Part A benefits exhausted on June 3, 20XX.

Two claims will be required for this inpatient stay.

Claim 1: Medicare Claim

FL 4 – Type of Bill. Enter “0111.”

FL 6 – Statement Covers Period. This patient was eligible for Medicare Part A from 031020XX through 060320XX.

FL 39-41 – Value Codes. Enter Value Code 80 – Covered Days and the number of days (85 days). Enter Value Code A2 and the coinsurance amount due.

FL 46 – Service Units. Enter 85 covered accommodation days.

FL 47 – Total Charges. Enter the total charges for the 85 covered days.

FL 50, Line A – Payer. Medicare is the primary payer.

FL 51, Line A – Health Plan ID. Enter “909,” the department’s legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL status code “01.”

FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare.

Claim 2: Medicaid Claim

FL 4 – Type of Bill. Enter “0121.”

FL 6 – Statement Covers Period. Enter the actual date of admission through the discharge date (March 10, 20XX through June 24, 20XX).

FL 18-28 - Condition Codes. Enter a “C1.”

FL 35-36 – Occurrence Span. Line A, enter code “74” with the non-covered date span that must equal the number of non-covered days listed as Value Code 81.

FL 39-41 – Value Codes. Enter Value Code 80 – Covered Days and the number of days under the Medicaid coverage (21 days). Enter Value Code 81 – Non-covered Days and the number of days that were covered under Medicare (85 days).

FL 46 – Service Units. Enter the number of covered accommodation days.

FL 47 – Total Charges. Total charges for all 106 days of care.

FL 48 – Non-covered Charges. Enter charges for the non-covered days of care, plus any other non-covered charges.

FL 50, Line A – Payer. Medicare is the primary payer.

FL 51, Line A – Health Plan ID. Enter “910,” the department’s legacy three-digit TPL code for Medicare Part B; a space; and then two-digit TPL status code “01.”

FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare Part B.

Note: The Medicaid claim requires a manual override and must be submitted to the billing consultant.

Billing Scenario 7

Medicare HMO Inpatient Crossovers for Disproportionate Share

The patient has medical coverage under a Medicare HMO, as well as Illinois Medicaid. This patient was admitted on July 16, 20XX and was discharged on July 20, 20XX. The Medicare HMO covered the inpatient stay and the department has no liability for this claim, but the department allows these inpatient days to be counted as part of the hospital's disproportionate share calculation. The hospital should submit a Medicare crossover claim, paying special attention to the form locators noted.

FL 18 – Condition Codes. Enter condition code "04" (Information Only Bill).

FL 39-41 – Value Codes. Enter value code A1 with an associated amount of "0.00."

Aside from the additional information above, claim preparation and submittal for these claims is the same as for other Medicare/Medicaid combination claims; i.e., the payer name must be listed as "Medicare," and the TPL code "909" for Medicare Part A and the Medicare HMO payment amount must be present.

Non-Covered Revenue Codes	
0601	Oxygen-Stat Equipment
0602	Oxygen-Stat. Equip
0603	Oxygen-Stat. Equip
0604	Oxygen-Portable Add-On
0624	FDA Invest Devices
0631	Single Source Drug
0632	Multiple Source Drug
0633	Restrictive Prescription
0637	Drugs / Self Admin
0640	Home IV Therapy
0641	Home IV Non-Routine
0642	IV Site Care
0643	IV Start
0644	Non-Routine Nursing
0645	Training-Patient
0646	Training-Disabled Patient
0647	Training
0648	Training
0649	Other IV Therapy Services
0650	Hospice Services
0660	Respite Care
0661	Respite Care - Hourly
0662	Respite - Hourly
0770	Preventive Care Services
0771	Preventive Care Services/Vaccine Admin
0780	Telemedicine
0822	Hemodialysis / Home Supplies
0823	Hemodialysis / Home Equipment
0824	Hemodialysis / Home Equipment
0825	Hemodialysis / Support Services
0832	Peritoneal Dialysis / Home Supplies
0833	Peritoneal Dialysis / Home Equipment
0834	Peritoneal Dialysis / Maintenance 100%
0835	Peritoneal Dialysis / Support Services
0842	CAPD / Home Supplies
0843	CAPD / Home Supplies
0844	CAPD / Maintenance 100%
0845	CAPD / Support Services

Non-Covered Revenue Codes	
0852	CCPD / Home Supplies
0853	CCPD / Home Equipment
0854	CCPD / Maintenance 100%
0855	CCPD / Support Services
0882	Home Dialysis Aide Visit
0941	Recreational Therapy
0942	Education / Training
0943	Cardiac Rehabilitation
0946	Complex Medical Equipment
0947	Complex Medical Equipment/Ancillary
0948	Pulmonary Rehabilitation
0949	Additional Other Therapeutic Services
0989	Professional Fees / Private Duty Nurse
0990	Patient Convenience Items
0991	Cafeteria / Guest Tray
0992	Private Linen Service
0993	Telephone / Telecom
0994	Television / Radio
0995	Nonpatient Room Rentals
0996	Late Discharge Charge
0997	Admission Kits
0998	Beauty Shop / Barber
0999	Other Patient Convenience Items
2100	General Classification
2101	Acupuncture
2102	Acupressure
2103	Massage
2104	Reflexology
2105	Biofeedback
2106	Hypnosis
2109	Other Alternative Therapy Services
3101	Adult Day Care, Medical and Social - Hourly
3102	Adult Day Care, Social - Hourly
3103	Adult Day Care, Medical And Social - Daily
3104	Adult Day Care, Social - Daily
3105	Adult Foster Care - Daily
3109	Other Adult Care