



# Handbook for Providers of Medical Services Chapter 100

## General Policy and Procedures

**Illinois Department of Healthcare and Family Services**

**Issued September 2017**

## Chapter 100

### General Policy and Procedures

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- [PBM-TPL Code Directory \(xls\)](#)
- [Error Codes \(xls\)](#)

## Foreword

Provider handbooks, along with recent [provider notices](#), will act as an effective guide to participation in the [Department's Medical Programs](#). Use of this handbook is intended for all Medicaid providers and contains general policies and procedures to which all enrolled providers must adhere.

It is important that both the provider of services, and the provider's billing personnel, read all materials prior to initiating services to ensure a thorough understanding of the [Department's Medical Programs](#) policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updates are posted to the [Department's website](#).

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive [e-mail notification](#), when new provider information has been posted by the Department. The e-mail notification process is not restricted and providers should share this feature with billing services, pay to providers (payees) or any other interested entities.

[Provider handbooks](#) are available on the [Department's website](#). A complete handbook consists of three chapters:

[Chapter 100](#) contains general policy, procedures and appendices applicable to all participating providers.

[Chapter 200](#) handbook series contains policy, procedures and appendices applicable to a specific provider type or to the provision of a specific medical service.

[Chapter 300](#) contains companion guides for all providers who submit the X12 (5010A1) or NCPDP (5.1 or 1.1 batch). It is a supplement to the Electronic Data Interchange transaction standards outlined within the current HIPAA Implementation Guides.

In addition to the handbooks listed above, the Department has prepared a manual containing helpful information on the Medicaid managed care program. [The Managed Care Manual for Medicaid Providers](#) is available on the Department's Care Coordination webpage.

Each [Chapter 200 handbook](#) is designated by an alphabetical character. Depending on the range of services, a provider may need more than one handbook from the Chapter 200 series. The organization and alphabetical numbering system of the Chapter 200 handbooks are as follows:

Type of Provider or Service	Handbook Number
Advanced Practice Nurse	A-200
Ambulatory Surgical Treatment Center	G-200
Audiology	E-200
Birth Centers	BC-200
Chiropractor	B-200
Dentist *	NA
Durable Medical Equipment	M-200
Encounter Rate Clinics	D-200
Healthy Kids	HK-200
Home Health Agencies	R-200
Hospice	K-200
Hospital	H-200
Laboratory Services	L-200
Local Education Agencies	U-200
Long Term Care **	N/A
Optometrist, Optician, Optical Company	O-200
Pharmacy	P-200
Podiatrist	F-200
Practitioners/Physicians	A-200
Imaging Services	A-200
Independent Diagnostic Testing Facilities	A-200
School Based/Linked Health Center Services	S-200
Screening, Assessment and Support Services	CMH-200
Supportive Living Facility	C-200
Therapy (Physical, Occupational and Speech)	J-200
Transportation	T-200

\*The handbook for dental providers is maintained by the Department's dental contractor. The [Dental Office Reference Manual](#) is available on-line or can be requested by phone at 888-281-2076, by fax at 262-241-7379, or by [email](#).

\*\*The Handbook for Providers of Long Term Care (LTC) Services is being updated. An electronic version of this handbook is not available at this time. Questions relating to policy and billing requirements for LTC providers should be directed to the Bureau of Long Term Care at 217-782-0545.

Providers must register for [e-mail notification](#). When registering, providers may select multiple provider/service categories listed. To ensure notification of all applicable information, providers are encouraged to check the category of "All Medical Assistance Providers," in addition to any other categories selected. The e-mail notification process is not restricted and providers should share this feature with billing services, pay to providers (payees) or any other interested entities.

## Contact Information

### Bureau of Professional and Ancillary Services

Phone: 877-782-5565

- Physicians, Chiropractors, Podiatrists, Advanced Practice Nurses, Independent Laboratories, Independent Diagnostic Testing Facilities, Imaging Centers, Portable X-ray, School-Based Clinics, Local Health Departments, FQHC, RHC, ERC, fee-for service hospitals, Home Health Services, Physical/Occupational/Speech Therapy, Local Education Agencies, and Community Mental Health Centers

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

- Non-Emergency Transportation

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

- Optometric

P.O. Box 19105  
Springfield, Illinois 62763-0001  
Attn: (Insert Consultant Name)  
Fax: 217-524-7120

- Prior Approval-Pharmacy

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

- Durable Medical Equipment, Audiology

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

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

P.O. Box 19124  
Springfield, Illinois 62794-9124  
Fax: 217-524-0099  
Review Fax Line: 217-558-4359

**Bureau of Hospital and Provider Services**

Phone: 877-782-5565

- Inpatient Hospital, Outpatient Hospital, Renal Dialysis, ASTCs, Hospice
- Provider Enrollment Services

P.O. Box 19128  
Springfield, Illinois 62794-9128  
Fax: 217-524-4283P.O. Box 19114  
Springfield, Illinois 62794-9114**Bureau of Managed Care**

Phone: 217-524-7478

- Marketing
- Contract Monitoring and Administration

201 South Grand Ave. East  
Springfield, Illinois 62763  
Fax: 217-524-7535**Bureau of Long Term Care**

Phone: 217-782-0545

- Supportive Living Facilities
- Nursing Facilities

201 South Grand Avenue East  
Springfield, Illinois 62763  
Fax: 217-524-7114**Bureau of Health Finance**

Phone: 217-782-1630

- Hospital Cost Reports
- Long Term Care Facility Cost Reports

201 South Grand Avenue East  
Springfield, Illinois 62763-0002  
Fax: 217-782-2812**Third Party Liability**

Phone: 217-524-2490

- Insurance Coverage Changes

P.O. Box 19149  
Springfield, Illinois 62794-9849  
Fax: 217-557-1174**Office of Inspector General**

- Bureau of Medicaid Integrity
- Fraud and Abuse Hotline

Phone: 217-782-0296  
404 North 5th Street  
Springfield, Illinois 62702  
Fax: 217-782-0313

Phone: 844-453-7283

AVRS Client Health Care Hotline  
AVRS Provider Health Care Hotline

Phone: 800-226-0768

Phone: 800-842-1461

HFS Health Benefits Hotline

In Illinois: 866-468-7543

Out-of-State: 217-785-8036

TTY: 877-204-1012

[Department of Human Services Helpline](#)

Phone: 800-843-6154

- [DHS Office Locator](#)

[Department of Children and Family Services](#)

Phone: 800-232-3798

Phone: 217-524-2029

- Advocacy Helpline

## Chapter 100

### General Policy and Procedures

#### 100 Healthcare and Family Services (HFS) Medical Programs — Basic Provisions, Authority and Objective

The [Department of Healthcare and Family Services \(HFS\)](#), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to about 25 percent of the State's population.

Illinois' Medical Programs cover children, parents or relatives caring for children, pregnant women, low income adults age 19 through 64, former foster care adults through age 25, veterans, seniors, persons who are blind, and persons with disabilities. To be eligible, adults must also be Illinois residents and U.S. citizens or qualified immigrants. Immigrants who do not have Medicaid qualifying status, may be covered for emergency medical care only, and are not eligible for transplantation services. Children are eligible regardless of immigration status. Individuals must also meet income and asset requirements. Income and asset limits vary by group. Descriptions of the various Medical Programs can be found in Topic 102.

One of the objectives 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. Covered services are specified in Topic 103 of this handbook and in the Chapter 200 handbook series.

For consideration of 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 Illinois' Medical Programs. Services provided must be in full compliance with applicable federal and state laws, Department Administrative Rule (89 Ill. Adm. Code, Social Services), the general provisions contained in this handbook and the policy and procedures contained in the [Chapter 200](#) handbook that applies to the specific type of service or provider specialty/subspecialty (provider type).

Payment for necessary medical services is made to enrolled providers when the service is not available without charge or is not covered by health insurance or other liable third parties. Both fiscal considerations and good administrative practice require the imposition of certain limitations and controls on the type and amount of medical care covered by the Department's Medical Programs. As specified by rule, prior approval requirements may be imposed for some services. Careful review of the handbook material will enable providers to identify specific program coverage and limitations.

## 101 Provider Enrollment

### 101.1 Illinois Medicaid Program Advanced Cloud Technology (IMPACT)

Illinois has a web-based provider enrollment system called Illinois Medicaid Program Advanced Cloud Technology (IMPACT). When enrolling in IMPACT, entities and individuals must designate their enrollment type as one of the following:

- Group ( e.g., physician group)
- Billing Agent
- Facilities, Agencies, and Organizations (FAO);
- Individual
  - Rendering /Servicing
  - Sole Proprietor
- Atypical (non- medical provider)
  - Atypical Individuals
  - Atypical Agency Groups

When enrolling, providers will designate a Provider Type, Specialty, and Subspecialty (if needed) in the IMPACT system.

#### **Group**

A Group is an entity that bills for health care services rendered by a group of practitioners. The entity may not have any licenses/certificates associated with their enrollment, such as a Group CLIA. A Group is required to have a Type 2 (organizational) NPI. The Group serves as a Billing Provider, meaning that the Group submits claims and/or receives payments on behalf of Typical Individual Sole Proprietors or Rendering /Servicing only providers. A Group may be classified as providing clinic, medical, dental, therapy and/or optical services, but is not the provider rendering the services.

#### **Billing Agent**

A provider may associate with a Billing Agent. In IMPACT, a Billing Agent is defined as: a business authorized to submit HIPAA compliant transactions; or, an entity that exchanges Electronic Protected Health Information (ePHI) on behalf of a health care provider or other authorized parties. Billing Agents may also be referred to as a Clearinghouse, a Software Vendor, or a Valued Added Network (VAN) depending on the relationship to the health care provider. In order for a provider to associate with a Billing Agent, the Billing Agent must be registered in the IMPACT system prior to the provider.

#### **FAO**

A provider may associate with an FAO. In IMPACT, an FAO is defined as an entity that provides health care services. FAOs include hospitals, nursing homes, laboratories, medical groups, etc., that have a Type 2 NPI. Licensing is required for this type of entity. In order for a provider to associate with an FAO, the FAOs must be registered in the IMPACT system prior to the provider.

**Individual**

An Individual is a provider who is termed “Typical”, meaning that the provider requires a Type 1 (individual) NPI for rendering health care services. The provider “Applicant Type” will be defined based on the way he/she bills for the services rendered.

- **Rendering/Service Provider**  
A Rendering/Service provider renders services to participants but does not submit claims directly to the State for reimbursement. The provider has to associate to at least one Billing Provider who will submit claims to the State on his/her behalf. The Billing Provider can be an Individual Sole Proprietor, FAO, or Group enrolled in IMPACT.

Example: An example of a Rendering/Service provider is a physician working for a hospital. He/she would enroll as a Rendering/Service provider only and would associate to a Billing Provider, which is the hospital in this case, as the hospital will be submitting claims on the provider’s behalf.

- **Sole Proprietor**  
A Sole Proprietor is a provider that owns his/her own practice/business. An individual Sole Proprietor will submit claims for services, either directly or indirectly through a Billing Agent, and/or receive reimbursement for the services. The providers may also associate to a Billing Provider such as FAO or Group who will submit claims to the State on their behalf.

Example: An example of an Individual/Sole Proprietor is a podiatrist who owns his/her own practice and submits claims directly to the State for reimbursement or associates to a Billing Agent to submit claims to the State on his/her behalf.

Note: An Individual/Sole Proprietor in some cases may serve as a Billing Provider. For example, if an Individual/Sole Proprietor employs an individual who renders health care services to participants, then this individual would enroll as a Rendering/Service provider and would associate to the Individual/Sole Proprietor who would serve as the Billing Provider.

**Atypical**

The Centers for Medicare and Medicaid Services (CMS) defines Atypical providers as providers who do not provide health care. These providers are not required to obtain an NPI. Some Atypical providers have never been required to enroll with the Department, such as emergency technicians, transportation drivers, dispatchers, homemakers and personal assistants serving waiver participants.

- An Atypical Individual works under his/her Social Security Number and may have an Employer Identification Number (EIN). Many providers in this group work with one or more of the Illinois State agencies, such as Department of Aging, Department of Children and Family Services, Department of Human Services and the University of Illinois Chicago – Department of Specialized Care for Children.
- An Atypical Agency has an EIN number and employees. A non-emergency transportation provider is an example of an Atypical provider.

## 101.2 Prerequisite Enrollment Steps for Providers

Before beginning the enrollment process in the [IMPACT](#) system, please determine whether you need to complete any of the prerequisite steps listed below.

- **Obtain a National Provider Identifier (NPI) Number** - A NPI is a unique ten-digit identification number issued by the federal Centers of Medicare and Medicaid (CMS). As required under the Health Insurance Portability and Accountability Act (HIPAA), health care providers must have an NPI and use the NPI in all HIPAA-related transactions. Providers may have multiple locations attached to one NPI, or separate NPIs for each location. Additional information on NPIs can be found on the federal [CMS HIPPA](#) webpage. Not all providers are required to have an NPI. If you are a health care provider who is a HIPAA-covered entity you must obtain an NPI.
- **Taxonomy Number** - A code used in billing HIPAA related transactions. The taxonomy number is selected by the health care provider based upon their education, license/certification and the services being rendered. Individual providers and organizations are required to indicate their taxonomy number when applying for an NPI. Providers who are required to have an NPI will need to enter their taxonomy number in IMPACT. Refer to the CMS website for additional information on [taxonomy codes](#).
- **Ensure a Certified W9 is on File** - Providers who receive state/federal funds directly from the Illinois State Comptroller for services rendered or provided to participants must have a certified W9 tax form on file with the [Illinois State Comptroller's office](#).
- **Professional Certifications or Licensures** - Providers must maintain current certification or licensure as a condition of participation in the Illinois Medicaid Program. If your profession requires certification or licensure in the State of Illinois, these qualifications must be active at the time of revalidation or enrollment in IMPACT. The [IMPACT](#) system verifies the following certifications and licensures:

- Illinois professional licenses
- Out-of-state medical licenses
- Medicare certifications
- American Board of Medical Specialties (ABMS)
- Clinical Laboratory Improvement Amendments (CLIA) Certifications
- Behavior Analyst Certification
- Deaf/Hard of Hearing Commission Licenses
- Board of Optician/Contact Lens Certifications
- Federal Aviation Administration Certifications

As applicable, [IMPACT](#) also verifies the following information:

- Criminal history background checks
  - Drug Enforcement Agency Numbers
  - Sanctions
  - Vital Statistics
  - Provider basic information
  - Driver's license/State ID
  - Vehicle plate numbers
  - Vehicle Identification Numbers (VIN)
  - Safety Training Certifications
- **Ensure the Appropriate Web Access** - [IMPACT](#) requires each provider to submit an active e-mail address. E-mail will become the primary mode of communication between contract agencies and providers, and an e-mail address is a required field for revalidating or enrollment in [IMPACT](#). In order to access the IMPACT provider portal you must use an Internet browser.

### 101.3 Participation Requirements

To be approved for participation in the Illinois Medicaid Program, providers must agree to the requirements detailed in [89 Illinois Administrative Code 140, Subpart B](#) as well as in relevant topics throughout the [Chapter 200](#) series handbooks.

- 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 non-covered 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 Program information regarding patients.
  - Furnish to the Department, in a 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 of this handbook.
  - If a provider accepts an individual eligible for medical coverage from the Department, 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 requirement, "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.
    - 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 the service if the total liability of the third party for the service is at least equal to the amount payable for the service from the Department.
  - Accepting 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.

#### **101.4 Conditional Enrollment Periods**

Enrollment of a vendor/provider in the Medicaid program is conditional for one year as noted in Illinois Public Aid Code [305 ILCS 5/5-5](#). During the period of conditional enrollment, the Department may terminate the vendor/provider's eligibility to participate in, or may dis-enroll the vendor/provider from the Department's Medical Programs without cause. Such termination or dis-enrollments are not subject to the Department's hearing process. However, a dis-enrolled vendor/provider may reapply without penalty. The Department is authorized to limit the conditional enrollment period for providers based upon the risk of fraud, waste, and abuse that is posed by the categorical risk level assigned to the provider as described in Topic 101.6 below.

#### **101.5 Provider Screening Based on Risk Level**

The Department is required to screen all initial provider applications, including applications for a new practice location and all applications received in response to a re-enrollment, reinstatement, or revalidation enrollment request based on a categorical risk level of "limited," "moderate," or "high." The risk level is assigned based on the type of provider. If a provider type can fit more than one categorical risk level, the highest level is assigned.

The provider screening process is conducted on: 1) all providers required to enroll through the [IMPACT](#) system; 2) any person with ownership or control interest of 5% or more in the disclosing entity; 3) any subcontractor in which the disclosing entity has a direct or limited ownership of 5 percent or more, and; 4) any fiscal agent or managing employee of the provider. For this purpose, "managing employee" is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

For additional information regarding conditional enrollment periods and screening risk levels, please refer to Appendix 6, Category of Risk of the Vendor, and the [Medical Provider Exclusion and Criminal History Background Check Screening](#) document available on the [IMPACT](#) webpage.

#### **101.6 Provider Discipline (Sanctions) — Exclusion from Participation in Federal Health Care Programs**

The Department will confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest of 5% or more in the

disclosing entity or any agent or managing employee of the provider through routine federal data base checks. These checks are conducted through the [Social Security Administration's Death Master File](#), the [National Plan and Provider Enumeration System \(NPES\)](#), the [List of Excluded Individuals/Entities \(LEIE\)](#) and the [System for Award Management \(SAM\)](#) which includes the [Excluded Parties List System \(EPLS\)](#).

The [IMPACT](#) system conducts an automated check of the above databases at enrollment, re-enrollment, revalidation, reinstatement and when a provider's information is modified in IMPACT. Any finding related to the exclusion of a provider is referred to the Department's [Office of Inspector General](#) (OIG) for review. If the OIG determines that the finding does not exclude the provider, the application is referred to the appropriate agency (i.e., HFS, DHS-DASA, DHS-DD, DoA). If the OIG determines that there is a valid exclusion, the OIG will deny the application and notify the provider.

### **101.7 Criminal History Background Checks**

The [IMPACT](#) system electronically processes an automated criminal history background check (CHBC) for each provider application and all persons listed within the application at enrollment, re-enrollment, revalidation, reinstatement and when a provider's information is modified in IMPACT. In addition, all enrolled providers and all persons listed on the application will have a CHBC conducted on a monthly basis.

Information is electronically collected from a variety of sources, including, but not limited to, county arrest and court records and the Illinois Department of Corrections. The following categories of criminal activity/history are screened: alcohol, arson, assault, breaking & entering, burglary, child abuse, computer crimes, drugs, embezzlement, illegal use/possession of firearms, forgery, fraud, homicide, kidnapping, larceny, property crimes, robbery, sexual misconduct, theft, traffic violations, vehicle crimes, other violence and weapon crimes. Any negative findings associated with the CHBC will cause the application to automatically be referred to the OIG for review. The OIG will review the provider's criminal history as defined by Illinois Public Aid Code [305 ILCS 5/12-4.25](#).

If the OIG determines that a CHBC finding does not exclude a provider, the application will be referred to the appropriate agency (i.e., HFS, DHS, DCFS) for further review. If the OIG determines that the provider's criminal history may exclude them from being a Medicaid provider, they will communicate with the appropriate agency to coordinate a decision regarding eligibility.

### **101.8 340B Program Enrollment**

The Department requires all providers eligible to participate in the federal [340B Drug Pricing Program](#) under Section 340B of the federal Public Health Services Act, be

enrolled as a 340B provider with the U.S. Department of Health and Human Services. Visit the 340B Drug Pricing Program's [Eligibility and Registration](#) webpage for more information on eligible 340B providers.

### 101.9 Termination of Provider Enrollment

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 Providers of Long Term Care Services or call the Bureau of Long Term Care at (217)782-0545.

Written notification of voluntary termination is to be sent to:

[Illinois Department of Healthcare and Family Services](#)  
Provider Enrollment Services  
Post Office Box 19114  
Springfield, IL 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 basis for such terminations or suspensions are set out in [89 Ill. Adm. Code 140.16](#). Department rules concerning administrative proceedings involving terminations or suspensions of medical vendors are set out in [89 Ill. Adm. Code 104, Subpart C](#).

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

## 102 HFS Medical Programs Overview

Payment can be made by the Department only for covered medical care and services provided to individuals who are eligible on the date of service. It is the responsibility of the provider to verify a patient's eligibility prior to providing services, except where prohibited by law (e.g., emergency ambulance services or hospital emergency room services). Information on how to verify patient eligibility can be found in Topic 108 of this handbook.

### 102.1 Applying for Coverage

Under an interagency agreement with HFS, the [Department of Human Services' \(DHS\)](#) Family Community Resource Centers (FCRCs) accept applications and determine the eligibility of individuals and families for Illinois' Medical Programs. DHS' FCRCs 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 should be contacted. In Cook County, providers should contact the appropriate neighborhood FCRC. To locate a FCRC use the DHS on-line [Office Locator](#).

HFS' Bureau of All Kids can determine eligibility for children, pregnant women, parents and caretaker relatives who apply by mail or web application, as well as applications that are transferred from the [Health Insurance Marketplace](#).

The [Department of Children and Family Services \(DCFS\)](#) is responsible for children who are youth in care of the State and covered by Medicaid or whose care is subsidized by DCFS. DCFS has responsibility for administering its own cases. Eligibility for DCFS cases is determined by DHS staff located within the DCFS office. 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 should be contacted.

#### 102.1.1 Application for Benefits Eligibility — ABE

[ABE](#) is Illinois' web-based application portal for all Medical Programs administered by HFS and the Supplemental Nutrition Assistance Program (SNAP) and Cash Assistance Program benefits, both administered by the Department of Human Services (DHS). Providers who are enrolled with the Department and certified under the [Medicaid Presumptive Eligibility Program](#) are encouraged to use ABE.

Through ABE, applicants, medical providers and community-based organizations certified under the Illinois Assister Program, can only apply online for the following HFS Medical Programs; All Kids, Family Care, Moms & Babies, Medical Assistance for Seniors and Persons with Disabilities (SPD), ACA Adults, and, former foster care clients. Assister Programs were created under the Affordable Care Act (ACA) so

community-based organizations could help support enrollment, outreach and education in both the Health Insurance Marketplace and Medicaid. Assistors are Certified Application Counselors (CACs). For information on what it means, and how to apply, to be a CAC go to the [Certified Application Counselor](#) organization website.

### 102.1.2 Prior and Retroactive Coverage

When an applicant initially applies for coverage they may request that their coverage is backdated to cover service they may have received for up to three months prior to the month of their application. The first time children are approved for the Family Health Plans of All Kids Share or All Kids Premium, the children may be eligible for payment of medical services received from two weeks before the date of application until the date their coverage under All Kids begins.

If the participant requests that the provider bill the Department for medical services rendered during the retroactive or prior coverage period, the provider should verify eligibility first. Refer to Topic 108 HFS Medical Card – Eligibility Verification.

Unless otherwise noted in the program descriptions that follow, participants in HFS' Medical Programs receive a Form HFS 469, HFS Medical Card, or, a DCFS youth in care, a CFS 930-C, Notice of Medicaid Coverage for DCFS Clients.

## 102.2 Medical Assistance Program

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act or 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.

## 102.3 The Family Health Plan Program

The Family Health Plan Program is a joint federal and state funded program operating under [Title XIX](#) and [Title XXI](#) of the Social Security Act, the [Illinois Public Aid Code \[305ILCS 5/1-1et seq.1\]](#) and the [Children's Health Insurance Program Act \[215ILCS 106\]](#) that authorizes the Department to administer an insurance program to assist families in providing medical coverage for their children. The Family Health Plan Program is comprised of four plans:

- All Kids Assist/FamilyCare Plan – All Kids Assist pays for a child's health care with no copayments or premiums from the participant. FamilyCare pays for a parent or caregiver relative's health care with copayments for some services. Refer to Topic 114, Patient Cost-Sharing.
- 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, Patient Cost-Sharing.

- 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, Patient Cost-Sharing.
- Moms and 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.

Refer to Topic 103 for a description of covered services. Please note, the medical services that are covered for participants in the Family Health Plans of All Kids Share and All Kids Premium are the same as those listed in Topic 103, with the exception of services provided through a waiver approved under Section 1915(c) of the Social Security Act and abortion services. Non-emergency transportation services are not covered for participants enrolled in All Kids Premium Level 2 program.

More information on these plans can be found on the [All Kids](#) webpage and the [FamilyCare](#) webpage.

#### **102.4 Senior and Persons with Disabilities (SPD) Program – Formerly AABD**

The Senior and Persons with Disabilities (SPD) Program provides medical coverage under Medicaid to seniors, persons who are blind and persons with disabilities with income up to 100 percent of the federal poverty level (FPL) and no more than \$2,000 of non-exempt resources. Refer to Topic 103 for a description of covered services.

#### **102.5 The Affordable Care Act (ACA) Adult Group**

Effective January 1, 2014, the Affordable Care Act (ACA) established a new federal eligibility group for medical coverage for adults age 19-64 without children and with incomes up to 138% FPL. These low-income adults may be eligible for health coverage through Medicaid. In addition, they are also eligible to receive, if qualified, Long Term Care Supports and Services (LTSS), including nursing home care; services in an Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/IDD); or services provided through Home and Community-Based Services (HCBS) waivers under subsection 1915(c) of the Social Security Act. For more information on the ACA Adult Group visit HFS’ [Affordable Care Act](#) webpage. Refer to Topic 103 for a description of covered services.

#### **102.6 Medicare Savings Program (MSP)**

The Department’s Medicare Savings Program (MSP) offers assistance to qualified Medicare beneficiaries in paying Medicare premiums, deductibles and coinsurance. The MSP consists of three programs:

- [Qualified Medicare Beneficiary \(QMB\)](#) - for eligible QMB participants, the Department pays the monthly Medicare premiums, deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLIB/SLMB) - for eligible SLIB/SLMB participants, the Department pays the monthly Medicare Part B Supplemental Medical Insurance premiums.
- Qualified Individual (QI) 1 – for eligible QI-1 participants, the Department pays the monthly Medicare Part B Supplemental Medical Insurance premiums.

For a brochure on the Medicare Savings for Qualified Beneficiaries visit the Department's [Medical Programs Brochures](#) webpage.

### 102.7 State Chronic Renal Disease Program

The [State Chronic Renal Disease Program](#) is operated by the Department under the authority of the [Renal Disease Treatment Act \[410 ILCS 430\]](#). This is a state only funded program that covers the cost of renal dialysis services for eligible Illinois residents diagnosed with chronic renal failure. The only medical service covered for participants is the dialysis itself.

If a patient has Medicare as their primary insurance, the State Chronic Renal Disease Program will still remain the secondary payer. If a patient does not have health insurance or their primary insurance does not cover the costs currently being covered through the State Chronic Renal Disease Program, the patient may be required to apply for coverage through HFS' ACA Adult Group or through Illinois' official healthcare marketplace: [Get Covered Illinois](#).

The application package for the State Chronic Renal Disease Program is supplied by the Department to social workers in renal dialysis centers. 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 will be, if any.

Participants of the State Chronic Renal Disease Program do not receive a medical card. Questions regarding applications or the eligibility of participants should be directed to the Bureau of Hospital and Provider Services at 1-877-782-5565. For more detailed information, please refer to the [State Chronic Renal Disease Program](#) webpage.

### 102.8 State Hemophilia Program

The State Hemophilia Program is operated by the Department under the authority of the [Hemophilia Care Act \[410 ILCS 420\]](#). This is a state only funded program that covers certain services when directly related to the participant's hemophilia.

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

For eligible children under the age of 21, the Department assists in coverage only for blood clotting factor. Other medical expenses are reimbursed by the University of Illinois at Chicago, [Division of Specialized Care for Children \(DSCC\)](#).

For eligible adults, the Department assists with expenses incurred for blood clotting factor and other medical expenses related to the disease, including: two comprehensive exams per year which includes physician and laboratory services; outpatient services.

If a patient has Medicare as their primary insurance, the State Hemophilia Program will still remain the secondary payer. If a patient does not have health insurance or their primary insurance does not cover the costs currently being covered through the State Hemophilia Program, the patient may be required to apply for coverage through HFS' ACA Adult Group or through Illinois' official healthcare marketplace, [Get Covered Illinois](#). Eligibility for this program is determined by the Department. Once approved, participants are sent an application every fiscal year to reapply. Applications are returned to:

[Illinois Department of Healthcare and Family Services](#)

Attn: State Hemophilia Program  
P.O. Box 19129  
Springfield, IL 62794-9129

Participants of the State Hemophilia Program do not receive an HFS Medical card. Questions regarding applications or the eligibility of participants should be directed to the Bureau of Hospital and Provider Services at 877-782-5565.

## **102.9 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 covers medical expenses for sexual assault survivors who seek emergency services from a certified hospital and who are not eligible for medical coverage through the Department and who are not covered for these services by a health insurance policy.

The medical services listed below are covered for participants in the State Sexual Assault Survivors Emergency Treatment Program when they are directly related to an alleged sexual assault. The Department may request medical records to verify that the services are eligible for reimbursement.

- Emergency Department/Room Physician Services
- Hospital Emergency Department/Room Visits
- Transportation to the hospital emergency department/room
- Follow-up services, such as practitioner services, laboratory services and pharmacy services for a period of 90 days with a hospital issued “Authorization for Payment Voucher”

Participants of the State Sexual Assault Survivors Emergency Treatment Program do not receive an HFS Medical Card. Inquiries on this program should be directed to the Bureau of Hospital and Provider Services at 877-782-5565 or to:

Office of the Attorney General of Illinois  
Crime Victims Compensation Program  
100 W. Randolph Street, 13<sup>th</sup> Floor  
Chicago, IL 60601 Telephone: 800-228-3368

### **102.10 Health Benefits for Persons with Breast or Cervical Cancer Program**

The Health Benefits for Persons with Breast or Cervical Cancer Program assists uninsured persons who have been diagnosed with breast or cervical cancer or a precancerous condition. The Illinois Department of Public Health administers the screening portion of the program. HFS administers the treatment portion of the program.

Eligibility for the program is determined by the Department’s Breast and Cervical Cancer (BCC) Eligibility Unit. Participants in the [Health Benefits for Persons with Breast or Cervical Cancer Program](#) receive the same medical benefits as participants in the Medical Assistance Family Health and ACA Adult Programs. Refer to Topic 103 for a description of covered services. Questions regarding the Health Benefits for Persons with Breast or Cervical Cancer program should be directed to the Department of Public Health Women’s Health line at 888-522-1282, TTY at 800-547-0466. Additional information on the program can be found on the [Illinois Breast and Cervical Cancer Program](#) website.

### **102.11 Health Benefits for Workers with Disabilities (HBWD) Program**

The Health Benefits for Workers with Disabilities (HBWD) Program assists persons with disabilities who wish to go to work, or increase their earnings without the fear of losing Medicaid benefits. Eligibility for this program is determined by the Department’s Bureau of Medical Eligibility Policy and Special Programs. Applications are submitted to:

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

Participants in the [HBWD Program](#) receive the same medical benefits as participants in the Medical Assistance Family Health and ACA Adult Programs. Refer to Topic 103 for a description of covered services. Questions regarding the HBWD Program should be directed to 800-226-0768. Additional information on the program can be found on the [Health Benefits for Workers with Disabilities Program](#) webpage.

### **102.12 Emergency Services for Noncitizens Not Meeting Immigration Status**

Persons age 19 or older, who are not eligible for medical benefits because they do not meet citizen/immigration requirements, may qualify for medical coverage for emergencies only. Persons applying for Emergency Services for Noncitizens Not Meeting Immigration Status must need, or have received emergency medical services in the month of their application, or during the three months before the month of the application. These individuals must meet all the program requirements for FamilyCare Assist, ACA Adult, or SPD medical coverage, except for a Social Security Number and verification of immigration status. People who meet these requirements are classified as noncitizens not meeting immigration status and are only eligible for short-term medical coverage for emergency care. Noncitizens not meeting immigration status are ineligible for cash and regular medical benefits, including organ transplants. Refer to Topic 103 for a description of covered services.

An ineligible noncitizen who comes to Illinois solely to receive medical care does not qualify. Medical coverage is given only to the person with the emergency medical condition; other non-citizen family members are not eligible.

## 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 describes how to determine which persons are eligible for each of the following lists of services.

### 103.1 Medical Assistance, Family Health Plan and ACA Adult Programs

The medical services that are covered for participants in Medical Assistance (Medicaid), the Family Health Plans and ACA Adults include the following:

- Abortion services in limited situations (89 Ill. Adm. Code [140.413](#))
- Advanced Practice Nurse Services (89 Ill. Adm. Code [140.435](#), [140.436](#))
- Ambulatory Surgical Treatment Center Services (89 Ill. Adm. Code [Part 146, Subpart A](#))
- Audiology Services (89 Ill. Adm. Code [140.497](#))
- Chiropractic Services (89 Ill. Adm. Code [140.428](#))
- Clinic Services (89 Ill. Adm. Code [140.460](#), [140.461](#), [140.462](#), [140.463](#), [140.464](#) and [140.467](#))
- Dental Services (89 Ill. Adm. Code [140.420](#), [140.421](#))
- EPSDT Services (89 Ill. Adm. Code [140.485](#))
- Family Planning Services and Supplies (89 Ill. Adm. Code [140.482](#), [140.483](#) and [140.484](#))
- Home Health Agency Visits (89 Ill. Adm. Code [140.470](#), [140.471](#), [140.472](#), [140.473](#) and [140.474](#))
- Hospice Services (89 Ill. Adm. Code [140.469](#))
- Hospital Ambulatory (Outpatient) Services (89 Ill. Adm. Code [148.140](#)).
- Hospital Inpatient Services (89 Ill. Adm. Code, [Part 148](#), [Part 149](#) and [Part 152](#))
- Hospital Emergency Department Services (89 Ill. Adm. Code [148.140](#))
- Imaging Services (89 Ill. Adm. Code [140.438](#))
- Laboratory (89 Ill. Adm. Code [140.430](#), [140.431](#), [140.432](#), [140.433](#), [140.434](#)).
- Long Term Care Services (89 Ill. Adm. Code [Part 147](#) and [Part 153](#))
- Medical Supplies, Equipment, Prostheses and Orthoses (89 Ill. Adm. Code [140.475](#), [140.476](#), [140.477](#), [140.478](#), [140.479](#), [140.480](#) and [140.481](#))
- Mental Health Services (89 Ill. Adm. Code [140.452](#), [140.453](#), [140.454](#), [140.455](#))
- Optical Services/Supplies (89 Ill. Adm. Code [140.416](#), [140.417](#) and [140.418](#)).
- Pharmacy Services (89 Ill. Adm. Code [140.440](#), [140.441](#), [140.442](#), [140.443](#), [140.444](#), [140.445](#), [140.446](#), [140.447](#), [140.448](#), [140.449](#), [140.450](#) and [140.451](#))
- Physician Services (89 Ill. Adm. Code [140.410](#), [140.411](#), [140.412](#), [140.413](#) and [140.414](#))
- Podiatric Services (89 Ill. Adm. Code [140.425](#), [140.426](#))
- Renal Dialysis Services (89 Ill. Adm. Code [148.140](#))

- Sub-acute Alcohol-Substance Abuse Services (89 Ill. Adm. Code [148.340](#) and [148.370](#))
- Telehealth Services (89 Ill. Adm. Code [140.403](#))
- Therapy Services (89 Ill. Adm. Code [140.457](#), [140.458](#) and [140.459](#))
- Transportation to secure covered medical services (89 Ill. Adm. Code [140.490](#), [140.491](#), [140.492](#), [140.493](#) and [140.494](#))

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), the Family Health Plan and ACA Adults. These include:

- Services provided through a waiver approved under Section 1915(c) of the Social Security Act and funded through the Department on Aging and the Department of Human Services.
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option and funded through the Department of Human Services and the Department of Children and Family Services; and sub-acute alcohol and substance abuse treatment services funded through the Department of Human Services.

### **103.2 Emergency Services Defined**

Throughout all the programs administered by the Department, the following definition of “emergency” is used, unless otherwise specified. Emergency is defined as “An emergency medical condition that occurs suddenly and unexpectedly, is caused by injury or illness, and requires immediate medical attention to prevent serious jeopardy to the patient’s health, or serious impairment to bodily functions or parts.”

## 104 Services Not Covered

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs, in accordance with [89 Ill. Adm. Code 140.6](#). 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:

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

Payments for services rendered after the death of a participant will be recovered by the Department. Other action may also be taken as appropriate, including possible civil or criminal fraud prosecution where warranted. The [Chapter 200](#) handbook series may contain other exclusions which are specific to a provider type (specialty/subspecialty) or service.

## 105 Managed Care and Care Coordination

The Department is committed to improving the health of Medicaid participants by providing access to, and coordination of, quality health care through reforming the systems that deliver medical care to participants. This commitment includes providing a Primary Care Provider (PCP) for every participant; maintaining continuity of care with that PCP; creating comprehensive networks of care around participants including primary care, specialists, hospitals and behavioral care; and offering care coordination to help participants with complex needs navigate the healthcare system pursuant to the Medicaid reform law (Public Acts [096-1501](#) and [97-689](#)) and the federal [Affordable Care Act](#) (Public Law 111-148). In 2011, the Public Aid Code was amended to require that at least fifty percent of all participants receiving comprehensive benefits be enrolled in some form of risk-based care coordination by January 1, 2015. As of the fall of 2016, over 60% of the 3 million participants were enrolled in a health plan that coordinates their health care.

Under the [Managed Care Programs](#) the term “health plan” refers to Managed Care Organizations (MCOs). MCOs include Health Maintenance Organizations (HMOs) and Managed Care Community Networks (MCCNs). HMOs are licensed by the Department of Insurance and MCCNs are provider or county owned and governed entities that operate similar to HMOs, but are certified by HFS rather than the Department of Insurance. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements with the Department. The HMOs and MCCNs are contractually required to offer the same comprehensive set of services to participants that are available to the fee-for-service population. In addition, MCOs may offer their members additional health and wellness benefits. In each Managed Care Program, the health plan provides or arranges care coordination services for their Medicaid participants pursuant to the requirements of the health plan’s contract with HFS.

Providers are encouraged to review the [Managed Care Manual \(pdf\)](#) that contains helpful information regarding the Medicaid managed care program for Providers enrolled in Medicaid.

### 105.1 Provider Participation in Health Plans

In addition to being enrolled with the Department through [IMPACT](#) (refer to Topic 101, Provider Enrollment and Federal Regulations at [42 CFR Part 455 Subpart E - Provider Screening and Enrollment](#)), providers must be enrolled in a managed care health plan, or have an arrangement with a plan, in order to provide services and receive reimbursement for rendering services to MCO enrolled participants. Contracting with a health plan does not automatically guarantee Department enrollment. Department and Managed Care enrollments are two separate enrollment processes. In addition, certain provider types such as transportation, dental, and optical providers may be required to enroll with managed care third party administrators.

A [care coordination map](#) showing the health plans and the counties they serve is available on the Department's website. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) also available on the Department's website.

Department enrolled providers are encouraged to contract with one or more of the managed care health plans to become part of their network(s). The contract negotiated between the provider and the managed care health plan dictates the relationship between the two parties, including payment provisions, prior authorization requirements, utilization review requirements, provider complaint and resolution procedures and panel limitations. Once a provider has contracted successfully with a health plan, the provider is considered an affiliated provider of the health plan.

## 105.2 Care Coordination

The Department has moved strategically to greater risk based managed care. The Department's initiatives include the expansion of its Medicaid Managed Care Programs in the mandatory managed care regions, Integrated Care Program (ICP), Medicare Medicaid Alignment Initiative (MMAI), Managed Long Term Services and Supports (MLTSS) Program and Family Health Program (FHP), while maintaining the Primary Care Case Management (PCCM) program in the non-mandatory counties of the State. These Managed Care Programs allow the Department to meet its goal of testing innovative care coordination models and improving the health of participants by providing access to, and coordination of, quality health care. A [care coordination map](#) showing the health plans and the counties they serve is available on the Department's website. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) available on the Department's website.

### 105.2.1 Integrated Care Program

The [Integrated Care Program \(ICP\)](#) was implemented in 2011 to improve the health care and quality of life for Illinois' Seniors and Persons with Disabilities (SPDs) enrolled in the Medicaid program, but not eligible for Medicare. ICP serves SPD participants in five mandatory regions in Illinois which includes: the Greater Chicago Region, the Rockford Region, the Quad Cities Region, the Central Illinois Region, and the Metro East Region. The integrated care delivery system brings together an individual's physicians, specialists, hospitals, nursing homes and other providers as part of an integrated team. The care is organized around the patient's needs to provide a more coordinated medical approach and improve health outcomes.

Additional information on the [Integrated Care Program](#) is available on the Department's website. A [care coordination map](#) showing the health plans and the counties they serve is available on the Department's website. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) available on the Department's website.

### 105.2.2 Medicare-Medicaid Alignment Initiative

The [Medicare-Medicaid Alignment Initiative \(MMAI\)](#) is a joint effort between the Department and the federal Centers for Medicare and Medicaid Services (CMS) to reform the way care is delivered to participants aged 21 and over who are eligible for both Medicare and Medicaid; these participants are also called Dual Eligibles. The demonstration integrates services covered in Medicare and Medicaid under one managed care program and combines financing streams to eliminate conflicting incentives between the two programs. The overarching goal of MMAI is to integrate benefits to create a unified delivery system that is easier for eligible participants to navigate. HFS and CMS contracted with MCOs serving the Greater Chicago and Central Illinois regions for this demonstration. The health plans assume financial risk for the care delivered to participants with responsibilities for robust care coordination efforts where performance will be measured and tied to quality measurement goals. MMAI is a voluntary program with passive enrollment. Passive enrollment is a process through which an eligible individual is enrolled by the Department into a contractor's plan following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision prior to the effective date of the enrollment.

Additional information on the [Medicare-Medicaid Alignment Initiative](#) is available on the Department's website. A [care coordination map](#) showing the health plans and the counties they serve is available on the Department's website. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) available on the Department's website.

### 105.2.3 Managed Long Term Services and Supports Program

The [Managed Long Term Services and Supports \(MLTSS\) Program](#) started in Illinois in 2016. It operates in the Greater Chicago Region and is a mandatory program for Dual Eligibles receiving long term services and supports who opt out of MMAI. The MLTSS participants include Dual Eligibles residing in a nursing facility and individuals on the following HCBS waivers: Supportive Living Facilities, Persons with Disabilities, Persons with HIV or AIDS, Persons with Brain Injuries, and Persons who are Elderly. Individuals receiving HCBS on a Developmental Disabilities (DD) waiver or residing in a DD facility are excluded from the MMAI and MLTSS programs.

In the MLTSS Program, the health plan only covers certain Medicaid services: non-Medicare long-term services and supports, non-Medicare behavioral health, and non-emergency transportation services. In addition, the participant's MLTSS health plan will cover the waiver services they receive at home, such as a personal assistant, homemaker, adult day care, or a home emergency response system. As a Dual Eligible participant, their medical benefits that are not covered by the MLTSS health plan are covered by Medicare or as Medicaid fee-for-service.

Additional information on the [Managed Long Term Services and Supports Program](#) is available on the Department's website. A [care coordination map](#) showing the health plans and the counties they serve is available on the Department's website. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) available on the Department's website.

#### 105.2.4 Family Health Plan Program

The Family Health Plan (FHP) Program was phased in to replace the former Voluntary Managed Care (VMC) Program across the 5 mandatory managed care regions. The FHP Program is a managed care program for children and their families, as well as adults eligible under the Affordable Care Act (ACA). The Department contracts with health plans to manage the provision of health care and care coordination for participants covered under the FHP Program.

A [care coordination map](#) showing the health plans and the counties they serve is available on the Department's website. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) available on the Department's website.

#### 105.2.5 Primary Care Case Management Program — Illinois Health Connect

The [Illinois Health Connect \(IHC\)](#) Program was implemented in 2006 and was the Department's first step toward implementing managed care throughout the State. During 2014 and 2015, the majority of participants previously enrolled in IHC joined managed care health plans for their care coordination services. IHC remains a choice for participants in the non-mandatory managed care regions; however, it is not a choice for participants statewide. Participants enrolled in IHC receive both care coordination and case management service from their Primary Care Provider (PCP). Additional information about the [Illinois Health Connect Program](#) is available on the IHC website.

### 105.3 Covered Services by Managed Care Plans

The following list identifies many covered services; however, this list is not an exhaustive list. Providers should refer to [89 Ill. Adm. Code, Part 140](#) for the complete list of Medicaid covered services.

The health plans are required to cover almost all services offered under Illinois Medicaid. They can also provide services beyond those covered under Medicaid, but health plans do so at their own expense. These additional services are approved by the Department before being offered to the health plan's members. Participants enrolled in a mandatory managed care program will receive coordination of these services by providers within the health plan's network whenever medically necessary.

- Assistive/Augmentation Communication Devices
- Audiology services

- Behavioral Health services, including subacute alcohol and substance abuse services and mental health services
- Blood, blood components and the administration thereof
- Chiropractic services
- Clinic services
- Dental services
- Diagnosis and treatment of medical conditions of the eye; may be provided by an optometrist operating within the scope of their license
- Durable and nondurable medical equipment and supplies
- Emergency services
- \*Family Planning services
- Home Health Agency services
- Hospice services
- 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
- Laboratory and x-ray services
- Medical procedures performed by a dentist
- Nursing facility (Long Term Care) services for the first 90 days.
- Nurse Midwife services
- Orthotic/prosthetic devices, including prosthetic devices or reconstructive surgery incidental to a mastectomy
- Outpatient hospital services
- Pharmacy services, including drugs prescribed by a dentist participating in the Department's Medical Programs provided they are filled by a managed care health plan network pharmacy
- Physician services, including psychiatric care
- Podiatric services
- Routine care in conjunction with certain investigational cancer treatments.
- Services to prevent illness and promote health
- Immunizations and services required to treat a condition diagnosed as a result of Healthy Kids (EPSDT) service
- Transplants
- Transportation to secure covered medical services

\*Participants enrolled in a managed care health plan can obtain family planning services from any enrolled provider, either in-network or out-of-network. Family planning services performed by an out-of-network provider may be billed directly to the managed care health plan

## 105.4 Non-Covered Services

There are some services that health plans are **not** responsible for covering. These services remain fee-for-service and should be billed to the Department, not to the health plans. These services include:

- Services in a State facility operated as a psychiatric hospital as a result of forensic commitment
- Services provided through a Local Education Agency (LEA)
- Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund
- Early Intervention (EI) services

## 105.5 Reimbursement

It is critical that providers check the Department's eligibility systems to verify a participant's enrollment in a health plan and identify the appropriate billing entity for dates of services provided (health plan, HFS, or some other source). Participant eligibility can be verified using one of the following resources: [Medical Electronic Data Interchange \(MEDI\) Internet Site](#), [Recipient Eligibility Verification \(REV\) System](#), or by calling the Automated Voice Response System (AVRS) — 800-842-1461.

### 105.5.1 Billing for Participants in Managed Care

Charges for services provided to participants enrolled in a managed care health plan under the Integrated Care Program, the Medicare-Medicaid Alignment Initiative, the Managed Long Term Services and Supports Program and the Family Health Plan Program must be billed directly to the health plan. Participants enrolled in a managed care health plan receive their dental services through the MCOs and the rendering dental provider must ensure they are credentialed before billing the appropriate health plan dental administrator.

Rates paid to providers of services in managed care are a contractual relationship between the health plan and the provider who negotiate their rate and payment structure. This includes reimbursement agreements that are based on quality and outcome incentives. HFS provides MCOs with Department reimbursement rates as MCOs may have contractual relationships with providers based on Medicaid rates. Managed care health plans are responsible for making payments to providers for covered services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. §1396a(a)(37)(A) and 215 ILCS 5/368a.

HFS pays managed care health plans on a full-risk capitated basis to cover the cost of Medicaid services and care coordination. Providers must provide services in accordance with each health plan's utilization policies and procedures, including procedures for prior authorization and billing. All questions, including billing questions, should be directed to the participant's health plan. For contact information refer to the [List of Contacts at Medicaid Health Plans](#) available on the Department's website.

Providers are responsible to bill the Health Plan directly for Health Plan Enrollees. Every Health Plan's Enrollee ID card contains the Enrollee's HFS RIN. Providers must verify coverage and Health Plan enrollment through one of the HFS automated systems using the participant's Social Security Number or the participant's RIN found on either the HFS Medical Card or Health Plan's Enrollee ID card.

It is critical that providers check the Department's electronic eligibility systems regularly to determine a participant's enrollment in a Health Plan. The three options are: 1) Recipient Eligibility Verification Program (REV); 2) the Medical Electronic Data Interchange (MEDI) system; or 3) the Automated Voice Response System (AVRS) at 800-842-1461.

HFS recognizes the importance of providers having an outlet for reporting issues they may have with Medicaid Health Plans if they cannot get these issues resolved by working through the Plan processes. The [provider portal](#) is for providers to submit complaints to HFS about issues they are experiencing with Illinois Medicaid Managed Care Organizations (MCOs) in an electronic and secure format.

The goal is to answer MCO-related questions promptly and ensure fair resolution of disputes involving MCOs and providers. Please allow HFS 2 business days to reply to an urgent complaint (immediate prescription needs or access to care needs, for example) and 15 business days for all other issues.

### **105.5.2 Billing for Participants in Illinois Health Connect**

Charges for services provided to participants enrolled in the Primary Care Case Management Program, Illinois Health Connect, should be billed directly to the Department on a fee-for-service basis in accordance with the reimbursement policies specific to the provider type or service rendered. Refer to the appropriate [Chapter 200](#) handbook for detailed billing instructions and prior approval requirements.

### **105.5.3 Billing for Participants Excluded from Managed Care-Care Coordination**

Some participants are excluded from mandatory participation in a Managed Care Program or IHC. Examples of these include participants with third party insurance, participants eligible for Medicaid through the Spenddown Program, participants with temporary coverage, or participants enrolled in the Health Benefits for Persons with Breast or Cervical Cancer Program. In these instances, no health plan or PCP will be identified on the participant's eligibility file and the provider will need to bill HFS on a fee-for-service basis in accordance with the reimbursement policies specific to the provider type or service rendered. Refer to the appropriate [Chapter 200](#) handbook for detailed billing instructions and prior approval requirements.

## 106 Recipient Restriction Program (RRP)

The Recipient Restriction Program (RRP) monitors utilization of participant medical services. The RRP identifies participants who demonstrate a pattern of receiving medical services that are not medically necessary. The identification of non-medically necessary services is based upon statistical norms and outliers in addition to review of this utilization by individual practitioners, pharmacists and other medical providers. If a determination is made that a participant has received medical services in excess of need or in such a manner as to constitute abuse of the Medicaid program, the Department may restrict the participant to one or more primary provider types.

The provider(s) the participant is restricted to must personally provide or authorize the Medicaid service for which the participant has been restricted. The Recipient Restriction Program applies to all Medical Assistance Programs administered by the Department; with the exception of full risk Managed Care Organizations (MCOs). Participants enrolled with a full risk MCO are subject to the MCO's policies and guidelines.

If a participant is restricted, the [MEDI](#) and [EDI](#) systems will display information regarding the participant's primary provider type(s). Providers who have a question about a participant's restriction status or a question as to whether a specific service requires prior authorization may call the Department's Recipient Restriction Program toll-free hotline at 800-325-8823.

When restricted, the participant is provided written notification. The notification advises the participant of the primary provider type(s) and provider(s) that the participant is restricted to, as well as, the time period of restriction. Recipient Restriction Program staff will initially assign a restriction provider(s) designation without regard to participant choice. The participant may change the initial restriction provider(s) designation without cause once during the time period of the restriction. To request a change in the initial provider(s) designation, the participant may notify the Department in writing or by calling the RRP toll-free hotline at 800-325-8823.

A restricted participant may change his or her designated provider **for cause** if one of the following circumstances is verified:

- Change in the participant's residence from the geographical area of the primary provider type.
- Change in the participant's medical condition that the primary provider type is unable to treat or refer to another provider for treatment.
- Death of the primary provider type.
- Disenrollment of the primary provider type from the Medical Assistance Program.
- Notice from the primary provider type that he/she or it will no longer serve as the primary provider type.

Once restricted the participant remains in the RRP for a minimum of twelve (12) months (four full quarters). No later than eighteen (18) months after the effective date of the restriction, the Department will reevaluate the participant's medical service usage to determine whether the restriction should still apply or be discontinued. If the outcome of the review is to continue the restriction, the participant will receive written notification from the Department.

The participant has a right to appeal the restriction decision. The participant must notify the Department in writing within 60 days after the Date of Notice that is on the participant's restriction notification letter. If an appeal is filed with the Department within ten (10) days of the Date of Notice, the participant will not be restricted until a fair hearing appeal decision has been made.

### 106.1 Medical Services Restricted by RRP

The Department will not authorize payment for restricted medical services that are not provided by or authorized by the participant's designated primary provider type(s). Emergency services, as defined in Topic 103, may be provided without prior authorization from the participant's designated primary provider type(s).

Payment for restricted medical services rendered by a provider other than the participant's primary provider type(s) will be authorized if the rendering provider receives prior authorization from the participant's primary provider type(s).

Authorization is documented via [Form HFS 1662 — Primary Care Physician/Pharmacy Authorization](#). Covered medical services not restricted under the participant's restriction program designation may be provided by any qualified provider enrolled in the Department's Medical Assistance Programs. Medical services that **are** subject to the RRP designation are as follows:

- 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 for instructions on billing for restricted services.

**106.2 RRP Restriction in a Managed Care Organization**

A participant who is restricted and chooses to enroll or is enrolled in a Managed Care Organization (MCO) by the Department is not subject to the Department's RRP policies.

The participant's current RRP restriction will be ended and the participant will be subject to the MCO's policies regarding services which may require the authorization of the participant's PCP.

## 108 HFS Medical Card - Eligibility Verification

Upon enrollment in one of the Department's Medical Programs most participants will be issued a paper [HFS Medical Card – HFS 469](#). Medical cards are issued annually and contain the names and Recipient Identification Number (RIN) of each individual on the case; however, the medical card is not proof of active medical eligibility. A family may receive more than one card in instances where the number of persons in the case is greater than the space available for printing on one card. Medical cards are issued when a:

- Medical case is approved.
- Person (s) is added to or deleted from the medical case.
- Redetermination or renewal of eligibility is processed.
- Person's name or date of birth is corrected on a medical case.
- Duplicate card is requested by the participant.

A sample of the [HFS Medical Card \(PDF\)](#) is available on the Department's website.

An HFS Medical Card – HFS 469 may be issued to a Qualified Medicare Beneficiary (QMB) who is not eligible for full medical benefits, but is eligible for Department consideration for payment of Medicare coinsurance and deductibles. The HFS Medical Card for this population is no longer marked with "QMB only."

Participants in a case with Spenddown receive an HFS Medical Card – HFS 469 upon enrollment. The card will be issued regardless of the Spenddown being met or unmet. Refer to Topic 113 for a more complete explanation of Spenddown.

Participants in the State Chronic Renal Disease Program, the State Sexual Assault Survivors Emergency Treatment Program and the State Hemophilia Program do not receive an HFS Medical Card.

### 108.1 Medical Eligibility Verification

As stated on the HFS Medical Card – HFS 469, the card does not guarantee eligibility or payment for services. Providers should verify eligibility even if the individual has a medical card, knows their Recipient Identification Number (RIN), or can give their Social Security Number and date of birth. In addition, providers are encouraged to ask for an additional piece of identification to verify the identity of the person presenting the card or providing the information. Providers may not charge participants to verify eligibility.

Medical cards that seem questionable (i.e., altered cards, cards containing handwritten entries, cards that do not follow the format of the [HFS 469](#)) should be investigated. If a provider suspects fraud or abuse regarding the use of a HFS Medical Card, the provider should call the Department's Medicaid/Welfare Fraud Hotline, at 844-453-7283/844-ILFRAUD.

When information needs to be updated on a participant's medical card, the participant should contact their local DHS FCRC, call the Change Report Hotline at 800-720-4166, or go online on the DHS website to [update their information](#). A person who loses eligibility and later re-enrolls will be assigned the same Recipient Identification Number (RIN). For additional information on MEDI, refer to Topic 112.6.1.

Participant eligibility can be verified using one of the following resources.

### **Medical Electronic Data Interchange (MEDI) Internet Site**

The Medical Electronic Data Interchange (MEDI) website allows authorized users online access to Department information.

- No charge to you or your authorized users to verify a participant's eligibility.
- No limit on the number of participant eligibility inquiries that can be made.
- Participant eligibility verification available seven days a week 24-hours a day.
- Participant eligibility inquiries can be made by using the:
  - Recipient Identification Number (RIN).
  - Participant's first and last name (as it appears in the HFS data bases) and their date of birth.
  - Participant's first and last name and Social Security Number.
  - Participant's Social Security Number.

### **Automated Voice Response System (AVRS) — 800-842-1461**

- No charge to you or your authorized users to verify a participant's eligibility.
- A limit of six (6) participant eligibility inquiries per phone call.
- Participant eligibility verification available seven days a week, 24-hour a day.
- Participant eligibility inquiries can be made by using the RIN and the date of service.

### **Recipient Eligibility Verification (REV) System**

The Recipient Eligibility Verification (REV) system is an interactive electronic system that allows providers to verify a participant's eligibility. For additional information on REV, refer to Topic 112.6.1.

### **Electronic Data Interchange (EDI) Service Trading Partners**

The Department is currently developing the Electronic Data Interchange (EDI) Service. This service will eventually replace the Recipient Eligibility Verification (REV) System. Many of the same services offered through REV will be available through the Department approved EDI trading partners. Providers will be notified when this change occurs.

## 270/271 Transactions

Providers may utilize ANSI X12N 270/271 Health Care Eligibility Benefit Inquiry and Response transactions to request and receive electronic batch file eligibility information.

### 108.2 Participant Medical Home Verification

Participants enrolled with a managed care health plan receive a member ID card from the health plan that contains the individual's HFS RIN. In addition, these participants receive a HFS Medical Card – HFS 469.

Managed care plan information is **not** listed on the HFS Medical Card. The [MEDI](#) and [REV/EDI](#) systems are valuable resources for providers to verify if a participant is enrolled in a managed care health plan. If a participant is enrolled with a managed care health plan, the participant should be directed to their health plan for assistance in receiving medical services. A [List of Contacts at Medicaid Health Plans](#) is available on the Department's website. A [care coordination map](#), showing the health plans and the counties they serve, is also available.

The MEDI and REV/EDI systems will provide the name of the participant's Primary Care Provider (PCP) if the individual is enrolled in [Illinois Health Connect \(IHC\)](#). If a participant is enrolled in IHC and has an assigned PCP, they should be directed to their PCP.

If a participant is not enrolled in a managed care health plan or does not have a PCP in IHC, any HFS provider who accepts their HFS Medical Card can see the participant.

### 108.3 Notice of Medicaid Coverage for DCFS Children

Children in DCFS custody or guardianship and children adopted with a monthly adoption/subsidized guardianship subsidy payment are eligible for services through HFS' Medical Assistance Program.

The Form CFS 930-C, Notice of Medicaid Coverage is issued to DCFS children. The CFS 930-C contains the child's name, RIN, caseworker name and caseworker ID. DCFS workers will use the CFS 930-C when a medical provider needs documentation of coverage.

Under this process, assignment of a temporary RIN for children entering DCFS care is done via a telephone call from the DCFS caseworker to DCFS' Medical Card Unit during regular business hours or to the Placement Clearance Desk after-hours, holidays and weekends. If the child remains in placement, a permanent HFS Medical Card – HFS469 will be issued.

#### 108.4 Coverage for Illinois Department of Corrections (IDOC) and Illinois Department of Juvenile Justice (IDJJ) Inmates

All inmates are assigned a case number. Inmates who qualify for one of the Department's medical programs are assigned the applicable category of assistance. Inmates who do not qualify for one of the Department's medical programs 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," 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, a hardcopy claim must be filled out in accordance with Department billing standards and mailed to HFS. The recipient identification number can be omitted from the claim. **Hospitals with questions regarding these types of bills may call HFS at 217-785-0710 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.

Individual practitioners (physicians, advanced practice nurses, podiatrists, therapists, dentists, audiologists) 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.

Any service **not** performed in these settings must be billed to the IDOC or IDJJ medical vendor for adjudication.

## 110 Record Requirements

### 110.1 Maintenance of Records

The record requirements listed below are applicable to all providers. Providers are encouraged to refer to the appropriate [Chapter 200](#) handbook for additional record requirements specific to a particular provider type/service, as well as [89 Ill. Adm. Code 140.28](#). The business and professional records required to be maintained are to be legible and kept in accordance with accepted business and accounting practices.

Providers are to maintain 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
- Original signed Billing Certification forms for each voucher received (see Topic 130, Payment Process)

Providers are to maintain 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.
- Other professional records required to be maintained by applicable federal or state law or regulation.

Professional records documenting the history, diagnosis, treatment services, etc., of a patient covered under one of HFS' medical programs 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 six (6) 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.
- 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, Payment Process).

## 110.3 Availability of Records

All required records 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 disruption to the professional activities of the provider.

The provider's business and professional records are to be maintained and available for inspection without prior notice by authorized Department personnel or designees on the premises of the provider for at least twelve (12) previous calendar months. Department personnel shall make requests in writing to inspect records more than twelve (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 be cause for sanction and/or termination from the Medicaid program and also cause for a referral to the appropriate law enforcement agency for further action.

## 111 Prior Approval Provisions

Prior approval (PA) 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 the [Chapter 200](#) handbook that pertains to that type of provider or service and also on the [fee schedule](#) for the service. Providers are responsible for obtaining prior approval before the service is rendered. Copies of the appropriate forms and instructions for use in requesting prior approval are included in the appendix of the appropriate [Chapter 200](#) handbook.

An approved PA request does not guarantee payment. Prior approval to provide services does not include a 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. Approval is not transferable to another provider. The approval is only valid for the provider who submitted the PA request.

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

The information that must be submitted with a PA request **may** include, but is not limited to, the following:

- 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
- Pick up and destination locations for non-emergency transportation

The specific information required will depend on the service or item for which prior approval is being requested. Refer to the appropriate [Chapter 200](#) handbook for further details.

To the extent possible, the request should describe 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 treat similar diagnoses or conditions. Anything

unique to the medical condition or living arrangement affecting the choice of a recommended service or item should be explained.

The Department will approve for a service/item if a less expensive service/item is appropriate to meet the patient's medical 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 (approval/denial) of requests for prior approval will be sent to the patient and to the requesting medical provider.

The provider is responsible for retaining the written notice of the PA for disposition for audit purposes. When a PA request is denied, the patient is 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 PA 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. Refer to the appropriate [Chapter 200](#) handbook for detailed instructions on obtaining prior approvals.

In general, 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 any 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 a prior approval request.

### **111.2 DCFS Youth in Care**

For services covered by the Medical Assistance Program, all HFS policies and procedures for prior approval apply to DCFS youth in care.

Services that are not covered by the Illinois Medical Assistance Program may be available to youth under the care of DCFS through a prior approval process by the appropriate Regional Office. Requests for prior approval for these services should be made using the appropriate HFS prior approval request form and submitted

directly to the Regional Office through which the DCFS youth in care is being served.

### 111.3 Participants of Managed Care Health Plans

For participants enrolled in a managed care health plan, providers should contact the specific plan regarding prior approval for non-emergency services. Prior approval for emergency services is not required for these participants, but the managed care health plan may require approval for post-stabilization services. Managed care health plans' prior approval policies may be different than the Departments.

Managed care health plans provide 24 hour access to health care professionals designated to authorize 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 approval was not denied within 60 minutes. The provider must continue to try to contact the plan after post stabilization services are rendered.

A [List of Contacts at Medicaid Health Plans](#) is available on the Department's website.

### 111.4 Prior Approval Contacts

Listed below are the various Department program areas or prior approval agents to be contacted by providers. They are specified by provider type and/or service. For detailed information on prior approval requirements, please refer to the [Chapter 200](#) handbook for the specific provider type or service.

- For prior approval of durable medical equipment and supplies; occupational, physical and speech therapies; podiatric items; communication devices; prosthetic devices; home health agency services; and bariatric surgery services contact:

[Illinois Department of Healthcare and Family Services](#)

Prior Approval Unit  
Post Office Box 19124  
Springfield, Illinois 62794-9124  
Telephone: 877-782-5565 Fax: (217) 524-0099

- For prior approval of optical materials contact:

[Illinois Department of Healthcare and Family Services](#)

Non-Institutional Services – Attention: Optical  
Post Office Box 19115  
Springfield, Illinois 62794-9124  
Telephone: 877-782-5565 Fax: 217-524-7120

- For prior approval of drugs that are non-preferred in the Department Drug File and for Refill-Too-Soon override requests and certain practitioner administered medications, as identified on the [Practitioner Fee Schedule](#), contact:

[Illinois Department of Healthcare and Family Services](#)

Pharmacy Unit  
Post Office Box 19117  
Springfield, Illinois 62794-9117  
Telephone: 800-252-8942

- For prior approval of dental services contact:

[DentaQuest of Illinois, LLC](#)

Prior Authorizations  
Post Office Box 2906  
Milwaukee, WI 53201-2906  
Telephone: 888-875-7482  
Fax: 262-241-7150

- For prior approval of non-emergency transportation, including non-emergency helicopter and fixed wing transports, contact:

[First Transit, Inc.](#)

Toll-free: 866-503-9040  
TTY: 630-873-1449  
Hours: 8 a.m. to 5 p.m. — Monday through Friday  
Closed on State Holidays

## 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 payers can be found in Topic 120, Other Payment Sources.

Instructions for paper claim preparation and submittal for specific service or provider types are included in the [Chapter 200](#) handbook and associated appendices. Instructions for electronic submittal of claims can be found in the [Chapter 300 Companion Guide](#).

The Department will not accept paper claim forms hand-delivered to HFS office buildings by providers or their billing entities. HFS will return all hand-delivered claims to the provider identified on the claim form.

### 112.1 Valid Billing Codes

ICD-10 diagnosis codes must be used when billing the Department. The appropriate diagnosis codes are reported in the "Diagnosis Code" area of the UB-04 and NIPS claim forms.

On non-institutional claim forms, all levels of Healthcare Common Procedure Coding System (HCPCS) codes, including CPT procedure codes, are recognized. HCPCS codes are also used on the outpatient UB-04 claim form. Inpatient UB-04 claims utilize ICD-10 procedure codes. NDC codes are used for drugs and some medical supplies.

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

### 112.2 Reimbursement

Provider specific fee schedules for reimbursement can be found on the Department's [Medicaid Reimbursement](#) webpage.

### 112.3 National Provider Identifier (NPI)

The Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers, pay-to providers (payees) and health plans.

The Centers for Medicare & Medicaid Services (CMS) developed the [National Plan and Provider Enumeration System \(NPPES\)](#) to assign these unique identifiers.

For detailed information on reporting NPIs on claims, refer to the [Chapter 200](#) handbook applicable to the provider type or service, and [Chapter 300, Companion Guide for Electronic Processing](#).

## 112.4 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 are systematically processed. The DCN consists of the date the claim was received by the Department (displayed as a Julian date) plus an individual number to identify the specific claim. A Julian Date Calendar is provided in General Appendix 1 of this handbook.

A claim will be considered for payment only if it is received by the Department no later than 180 days from the date on which the services or items were provided. This time limit applies to both initial and resubmitted claims. Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid. For hospital inpatient claims, the 180 days begins on the date of discharge.

Claims which are not submitted and received in compliance with the time limits for claim submittal will not be eligible for payment by the Department and the State shall have no liability for payment thereof. Refer to [89 Ill. Adm. Code 140.20](#) for additional information on time limits for filing a claim.

### 112.4.1 Exceptions to 180-Day Time Limit

**Exceptions are only considered when the changes affect a provider's ability to submit claims for reimbursement.** The 180 day time limit for claim submittal will not apply, or is modified, in the following situations:

- Claims received from a provider operated by a unit of local government with a population exceeding 3,000,000 when local government funds finance federal participation for claims payment – subject to a timely filing deadline of 12 months from date of service. The 12 month deadline extends to any exceptions that indicate a 180 day extension for all other providers. Timeliness for replacement claims, or a void & rebill transaction, is the same as that indicated below.
- Medicare crossovers (Medicare payable claims) – subject to a timely filing deadline of 2 years from the date of service. Claims may be submitted electronically or on the paper HFS 3797 (non-institutional claims) or UB-04 (institutional claims).

- Medicare denied claims – subject to a timely filing deadline of 2 years from the date of service. Submit a paper HFS 2360, HFS 1443, HFS 2209, HFS 2210, or HFS 2211 with the EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach Form HFS1624, Override Request form, stating the reason for the override. For institutional claims, submit a paper UB-04 with the EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach Form HFS1624A, UB-04 Override Request form, stating the reason for the override
- New provider enrollment, provider re-enrollment, addition of a new specialty/sub-specialty, or addition of an alternate payee – **applies only to those claims that could not be billed until the enrollment, re-enrollment, addition of a new specialty/sub-specialty, or payee addition was complete.** The 180 day period shall begin with the date the enrollment, re-enrollment, or update was recorded on the provider file. Attach form HFS 1624, Override Request (NIPS providers) or HFS 1624A, UB-04 Override Request (institutional providers), stating the reason for the request to a paper claim form. Upon receipt of claims with an override request, HFS staff will verify that the claim(s) could not have been billed without the change to the provider file. Requests for override due to a provider file change must be requested within 180 days of a claim rejecting due to the discrepancy.
- Retroactive Participant eligibility – 180 days from the Department’s system update viewed on MEDI when verifying eligibility. Please ensure eligibility verification is for the date of service and not current date or date range. Attach a HFS 1624, Override Request Form (NIPS providers) or HFS 1624A, UB-04 Override Request Form (institutional providers), stating the reason for the override to a paper claim form.
- Replacement or Void/Rebill of an entire claim or single service line (NIPS claims) – The Department will accept electronic transactions submitted through MEDI or via 837P files to void or replace a paid claim (includes claims paid at \$0), or a claim that is pending to pay, if submitted within 12 months from the original paid voucher date.

**Note:** The functionality of allowing replacement claims and claims to be re-billed following a void is for the purpose of correcting errors on previously submitted and paid claims (e.g. incorrect provider number, incorrect date of service, incorrect procedure code, etc.) and **not** for the purpose of billing additional services.

- Replacement claims (NIPS claims) – To replace a single service line or entire claim, enter Claim Frequency “7”. Detailed instructions on how to replace a claim electronically can be found in the Chapter 300, 837P Companion Guide. This method is preferred as it requires no manual override.

- Void & Re-bill (NIPS claims) – This process involves two steps. The void portion may be completed electronically or on paper. Please refer only to step #1 below for a void with no re-bill.
  1. To electronically void a single service line or an entire claim, enter Claim Frequency “8”. Detailed instructions on how to void a claim electronically can be found in the Chapter 300, 837P Companion Guide. A paper void may be completed by submitting a NIPS Adjustment Form HFS 2292. Instructions on how to complete the form are located in Chapter 100, Appendices.
  2. Following completion of the void, a new original claim must be submitted within 90 days of the void DCN and may require manual override. If manual override is required, attach form HFS 1624, Override Request Form, stating the reason for override to a paper claim. Community Mental Health Providers (provider type 036) who do not have a paper billing option should contact a billing consultant for override instructions.

**Note:** For void or replacement claims the following data elements must match the original claim:

- Document Control Number - The 17-digit DCN from the original paid claim is required. Using the 12-digit DCN from the paper remit
  - Add ‘201’ to the beginning of that 12-digit DCN
  - Add **either** the 2-digit section number to void or replace a single service line, **or** ‘00’ to void or replace an entire claim, to the end of the 15-digit number
  - Provider NPI, or for atypical providers the HFS Provider Number
  - Recipient Identification Number
- TPL – Claims must be submitted to the Department within 180 days after the final adjudication by the primary payer. Claims may be submitted electronically or on paper and must have TPL fields completed. Timely submission will be calculated systematically based on the TPL adjudication date. For this reason, no override request is necessary.
  - In the case of long term care facilities, once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

- Split bill – Claims must be submitted to the Department within 180 days from the date on the HFS 2432 (Split Billing Transmittal/Spenddown Form). Attach the HFS 2432 with form HFS 1624, Override Request (NIPS) or HFS 1624A, UB-04 Override Request (institutional providers), stating the reason for the override to a paper claim form. TPL fields must be completed.
- Primary TPL Recoupment – Claims must be submitted within 180 days from the date of the recoupment notification letter. Attach a copy of the recoupment notification letter and form HFS 1624, Override Request (NIPS) or HFS 1624A, UB-04 Override Request (institutional providers), stating the reason for the override to a paper claim form. TPL fields on the paper claim must be completed when applicable.
- Local Education Agencies (LEAs) – Claims must be submitted to the Department within 18 months from date of service. Claims may be submitted electronically or on the paper HFS 1443.
- Errors attributable to the Department or any of its claims processing intermediaries that results in an inability to receive, process or adjudicate a claim – the 180-day period shall not begin until the provider has been notified of the error by either the date on the paper voucher/remittance advice or the fix date on the Claims Processing System Issues webpage. For override information refer to the rebilling instructions posted on the webpage, or contact a billing consultant at 877-782-5565 in the absence of notification on the webpage.

### 112.5 Resubmitting Claims

Providers should resubmit claims only if their claims fail to appear in the [MEDI System](#) thirty (30) days after submission to the Department. Refer to Topic 131, Billing Inquiry Process, for information on how to check the status of a claim.

The provider should prepare a new original claim for submittal to the Department. It is the responsibility of the provider to ensure that a claim is submitted timely.

**Exception:**

Prior to December 1, 2016, claims for long-term care (LTC) providers were generated by the Department based on information reported on Form HFS 3402-LTC Pre-Payment Report. Discrepancies on these claims were not to be rebilled as described above.

Effective with dates of service on or after 12/01/2016, LTC providers must direct bill the Department for their services in a manner similar to that utilized for Medicare services. This process is detailed on the [Long Term Care Direct Billing Resources](#) webpage on the Department's website.

An electronic version of the Handbook for Providers of Long Term Care (LTC) Services is not available at this time. Questions relating to policy and billing requirements for LTC providers should be directed to the Bureau of Long Term Care at (217) 782-0545.

## 112.6 Electronic Claim Submittal

In addition to reading the information contained in this topic, providers should also refer to the [Chapter 200](#) handbook applicable to their provider or service type and the [Chapter 300 Companion Guide](#) for electronic billing.

All electronically submitted claims are subject to the same edits and are reported on a paper HFS 194-M-1 remittance advice in the same manner as paper claims. The same requirements for electronic claim submission, including verifying patient eligibility, billing known insurance carriers, and reporting [TPL](#) payments, exist as for paper claims. Claims that require an attachment cannot be submitted electronically. These claims must 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 rendered the services and submitted the electronic 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 paper claims as described in Topic 112.7.1 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 law, whichever is longer.

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 paper claims must be submitted until notification is given by the Department to resume electronic billing.

### 112.6.1 Electronic Claims Capture (ECC) — MEDI, REV/EDI Service Systems

Providers may submit all non-institutional claims, other than pharmacy claims, as well as institutional claims billed on form UB-04, electronically through the [Medical Electronic Data Interchange \(MEDI\)](#) Internet site or a [REV Vendor/Electronic Data Interchange Service \(EDI\)](#) trading partner. The Department accepts non-institutional claims in the X-12 837 Professional standard, Version 5010A and institutional claims in the X-12 837 Institutional standard, Version 5010A. Pharmacies must bill electronically through the [Pharmacy Benefits Management System](#).

## **[Medical Electronic Data Interchange \(MEDI\) Authorization System](#)**

The MEDI Authorization System provides a repository for authorization information for access to HFS' Internet applications. Because of federal Internet standards, as well as HIPAA regulations, HFS requires authorization for some applications provided through the Internet. In order to gain access to these applications, a person must register in the MEDI system. The [MEDI Getting Started](#) page presents what is required to use these applications.

The MEDI system is designed to be available 24-hours a day, 7 days a week. The system is down for maintenance every day between 3:00 a.m. and 3:30 a.m. The Payee Registration function is only available from 8:00 a.m. to 5:00 p.m. CST, Monday through Friday.

Access to the [Medical Electronic Data Interchange \(MEDI\)](#) website is provided after successfully obtaining a 'digital certificate' from the Illinois Department Central Management Services (CMS).

To meet the requirements of HIPAA, the Department provides the Internet Electronic Claims (IEC) System to handle the electronic transfer of HIPAA-compliant formats. The main purpose of the IEC System is to provide registered MEDI users the ability to perform basic processing functions.

Users of the MEDI system will have access to certain IEC functions depending on the authorization they are granted by their employer's MEDI administrator(s).

Following is a list of functions that are available.

- Eligibility Inquiry: allows providers to check a patient's eligibility.
- Claim Status: allows providers to check on the status of a claim. This function is available Monday through Friday from 8:00 a.m. to 5 p.m. CST.
- Upload File(s): allows an authorized user to upload one or more transactions and more than one transaction type.
- Download File(s): allows an authorized user to download one or more transaction and more than one transaction type.
- Remittance Advice (835): allows the user to view and download Electronic Remittance Advices (ERAs).
- Direct Data Entry: allows real-time entry and submission of claims.

Refer to the [MEDI-Registration Toolbox](#) for more detailed information on MEDI and the registration process.

## **[Recipient Eligibility Verification \(REV\)](#)**

The [Recipient Eligibility Verification \(REV\)](#) system is an interactive electronic system which allows providers to: verify a participant's eligibility; submit claims electronically; check the status of claims in processing, and; download batches of claim information.

Providers access the REV system through vendors (independent contractors) who have agreements with the Department to provide this service. REV vendors provide this service by various methods, including: standardized software for use on existing PCs; point-of-service devices, and; custom programming of a provider's existing computer system to accept and transmit the Department's data.

All current [REV](#) vendors also act as clearinghouses for other public and private payers. 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 payers. 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.

### **Electronic Data Interchange (EDI) Service Trading Partners**

The Department is currently developing the Electronic Data Interchange (EDI) Service. This service will eventually replace the Recipient Eligibility Verification System. Many of the same services offered through REV will be available through the Department approved EDI trading partners. Providers will be notified when this change occurs.

### **112.6.2 Pharmacy Benefits Management System**

The Pharmacy Benefits Management System is a real time, point of sale claim adjudication system by which pharmacy providers may submit claims for pharmacy services to the Department. In addition to real time, point of sale claim adjudication, claims may also be submitted through direct data entry.

Pharmacy providers must be enrolled with the department to submit claims. The Pharmacy Benefits Management System uses the National Council of Prescription Drugs Program (NCPDP) Version D.0 billing format. The Department's [payor sheet](#) with detailed billing requirements is available on the Department's website.

Questions regarding NCPDP should be directed to the National Council of Prescription Drugs Program at 480-734-2870, or by fax at 877-647-0295, or by e-mail at [pharmacyhelp@ncdpd.org](mailto:pharmacyhelp@ncdpd.org)

Questions regarding the payor sheets should be directed to the Department's Bureau of Technical Support at 217-524-7288.

## 112.7 Paper Claim Submittal

Additional instructions for paper claim preparation and submittal for specific services or provider types are included in the [Chapter 200](#) handbook and associated appendices.

### 112.7.1 Claims Preparation

Refer to the [Chapter 200](#) handbook and appendices for guidelines specific to a provider or service type.

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 must be an 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 are submitted to the Department only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. The Department offers a claim scanability/imaging evaluation. Turnaround on a claim scanability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address:

[Illinois Department of Healthcare and Family Services](#)  
201 South Grand Avenue East  
Second Floor—Data Preparation Unit  
Springfield, Illinois 62763-0001  
Attention: Provider/Image System Liaison

Note: HFS does not utilize the CMS 1500, Health Insurance Claim Form. Claims submitted on a CMS 1500 will not be processed or returned by the Department.

### 112.7.2 Mailing of Claims

All paper claims with the exception of the UB-04 are to be mailed in the pre-addressed envelopes supplied by the Department as specified in the [Chapter 200](#)

handbook and appendices. Any deviation from this requirement may delay processing.

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 directed in the Chapter 200 handbook for the specific provider or service type being billed. If the Department requests additional information in order to process a claim, the additional information should not be mailed to the Department without a claim attached.

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

- Review all forms for accuracy and completeness
- Do not fold or damage claims
- Do not staple, paper clip, or otherwise attach claims together
- Do not use liquid correction fluid or correction tape on claims
- Mail as many claims as possible in one envelope
- Place claims in envelope with all pages facing in the same direction. Keep each claim type separate
- Do not mail claims that require special handling in the same envelope with routine claims

### 112.7.3 Ordering of Claim Forms and Envelopes

Forms and envelopes should be requested on the Department's [website](#). Both a numerical and alphabetical list of [Medical Programs Forms](#) are also available online.

If the form needed is not listed as a selection on the on-line forms request, provide the form number and quantity on the fields at the bottom of the online form.

Requests for forms submitted by mail must be submitted using [Form HFS 1517-Provider Forms Request](#), and mailed to the preprinted address on the top of the form.

Providers 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](#) handbook for the specific type of provider/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) the name and provider ID of at least one HFS enrolled provider.

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

### 112.8 Claim Procedures for Medicare Covered Services

Charges for deductible and coinsurance amounts due for Medicare Part B covered services are to be submitted to the Department only after adjudication by the Medicare Administrative Contractor (MAC), or Medicare Advantage Plan (MAP).

Services billed to the MAC or Durable Medical Equipment (DME) MAC as first payer will be “crossed over” to the Department electronically for payment consideration of coinsurance or deductibles or both. Claims from MAPs are not automatically crossed over. Claims should **not** be submitted directly to the Department when the Medicare Remittance Notice displays a message or code stating that the claim has been forwarded to the [Illinois Department of Healthcare and Family Services](#). A service that has been rejected for payment by Medicare may be submitted to the Department for payment consideration only when the reason for nonpayment is either that the:

- Patient was not eligible for Medicare benefits, or
- 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 MAC or MAP.

Charges for deductible and coinsurance amounts due for Medicare Part A covered services are not automatically crossed over to the Department for adjudication. Providers are responsible for submittal of those claims to the Department after adjudication by Medicare.

Claims for participants enrolled in the [Medicare-Medicaid Alignment Initiative \(MMAI\)](#) should be submitted to the appropriate MMAI plan. Enrollment in the MMAI can be verified on [MEDI](#) or [REV/ EDI](#) under the “Managed Care Organization” segment.

For further information on the Department’s payment policies for services to Medicare participants, refer to Topic 120, Other Payment Sources. For detailed billing instructions on such claims, refer to the [Chapter 200](#) handbook specific to the type of provider/service being billed.

### 112.9 Claim Procedures for Recipient Restriction Program (RRP) Services

Claims for services to participants who have been restricted under the RRP to one or more primary provider types require no special forms or procedures as long as the services are provided by the designated primary provider type(s). Refer to Topic 106 for additional information on the RRP.

For payment consideration, claims for restricted medical services rendered by a provider other than the participant's designated primary provider type(s) must be authorized by the participant's designated primary provider type(s). Authorization is documented on a [Form HFS 1662](#). The HFS 1662 is used by the designated primary provider type to refer an RRP participant to another provider for necessary services which the designated primary provider type cannot provide.

A completed [Form HFS 1662](#) must be attached to all non-pharmacy paper claims for restricted services rendered by a provider other than the participant's designated primary provider type. Form HFS 1662 may authorize one service date only. Therefore, the date of service on a claim must be for the date specified on Form HFS 1662. Multiple services billed on a single claim form may be attached to a single Form HFS 1662 provided that all dates of service are the same. The [Form HFS 1662](#) and the appropriate billing form must be mailed to: [Illinois Department of Healthcare and Family Services](#), Post Office Box 19118, Springfield, IL 62794-9118.

These claims should not be resubmitted to the address listed above until a completed Form HFS 1662 authorizing the service(s) and date of service is obtained from the participant's designated primary provider type(s).

Claims submitted by a pharmacy for a participant receiving prescriptions from a prescriber (other than the physician or physician employed by the clinic that the participant is restricted to) should be submitted electronically whenever possible. If a paper claim (HFS 215CF – Drug Invoice) is prepared, then the Form HFS 1662 must be attached when submitted. See [Chapter P-200 — Handbook for Providers of Pharmacy Services](#) for detailed pharmacy billing instructions for electronic claim submissions for participants who are restricted under the RRP.

## 113 Spenddown

The [Spenddown Program](#) provides medical coverage to participants who would otherwise be ineligible because of income or assets or both which exceed the Department's standards.

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

- 1) The participant's Spenddown obligation is determined on a monthly basis; whereas, deductibles in most insurance plans are determined on an annual basis.
- 2) The amount of the monthly Spenddown obligation is based upon the participant's income and assets; whereas, 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 participant's responsibility and which are the Department's is made chronologically based on date of service; whereas, most insurance plans base this decision on the date the plan receives the bill for adjudication.

Spenddown participants receive an [HFS Medical Card – HFS 469](#) upon enrollment. The card will be issued regardless of the Spenddown being met or unmet. Providers must verify medical eligibility for **each date of service**. Eligibility can be verified using one of the following resources:

- [Medical Electronic Data Interchange \(MEDI\)](#) Internet Site
- [Recipient Eligibility Verification \(REV\) System](#)
- Automated Voice Response System (AVRS) 800-842-1461
- Provider Eligibility Hotline at 217-557-6544
- Health Benefits Hotline at 800-226-0768, Option 7

Participants who have private insurance or other [Third Party Liability \(TPL\)](#) coverage, the portion of the medical bills and receipts which is paid by the [TPL](#) resource is not counted toward meeting the Spenddown obligation. TPL information can be found when verifying a participant's eligibility through MEDI.

If a provider accepts an individual as a Medicaid participant, all medical charges up to the amount of the Spenddown obligation is the participant's responsibility. For example:

- If a provider renders a service to a participant, who has a \$300 monthly Spenddown, and the Department's maximum rate for the service is \$275, and

the provider's 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.

- If a participant's Spenddown obligation is \$60, and he or she receives a medical service for which the provider's charge is \$80, but the Department's maximum rate is \$65, the Spenddown obligation would be satisfied by the provider's charge. In this scenario, 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.

### 113.1 Pay-In Spenddown

Seniors and persons with disabilities (SPDs) who are approved for a Spenddown case may enroll in the Pay-In Spenddown option. Pay-In Spenddown allows participants to pay the amount of their monthly Spenddown to HFS, rather than having to accumulate and submit bills and receipts for medical expenses on a monthly basis to their DHS [Family Community Resource Center \(FCRC\)](#) office for review. Monthly statements of the Spenddown amount are issued to the participant who may "pay in" via money order, cashier's check, debit or credit card payment.

For additional information refer to the Department's brochure on [Spenddown](#).

### 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 [Family Community Resource Center \(FCRC\)](#) will notify the participant when they have met their Spenddown and will advise which medical bills the participant is responsible for paying and which medical 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 the forms to the medical provider.

Upon request, the FCRC may send a Form HFS 2432 directly to the medical provider. The provider has up to 180 days from the date on the HFS 2432 to submit the claim.

A Form HFS 2432 – Split-Billing Transmittal is issued only for those providers who are eligible for payment for services rendered on the split-bill day. Form HFS 2432 will not be issued for bills which are the responsibility of the patient.

When services are billed for a date that is determined to be a split-bill day, a Form HFS 2432 must be attached to the paper claim. 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 participant's FCRC. Claims should not be submitted to the Department unless a Form HFS 2432 has been received. If a Form HFS 2432 is not received, the participant remains responsible for the charges incurred on the beginning date of eligibility.

Specific instructions for completing a claim form to which a Form HFS 2432 is attached can be found in the appendices of the [Chapter 200](#) handbook applicable to the provider type/service being billed.

## 114 Participant Cost-Sharing

Payments made by the Department to providers for services to eligible participants are considered payment in full. If a provider accepts a patient as a Medical Programs participant, the provider may not charge the participant 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 (e.g., primary TPL deductibles and co-payments) be charged to eligible participants for any covered services under any of the programs described in Topic 102 of this handbook.

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

Providers can verify copayment information when checking participant eligibility. Information on how to verify participant eligibility can be found in Topic 108, HFS Medical Card – Eligibility Verification. Additional information may be found at 89 Ill. Adm. Code [Section 140.402](#) and [Section 148.90](#).

### 114.1 Copayments

Appendix 5 of this handbook identifies the eligibility categories, specific procedure codes/services subject to copayments, the copayment amounts and, if applicable, the annual copayment maximum.

Participants covered by Family Care Assist, All Kids Share, and All Kids Premium Level I and Level 2, Medicaid adults (SPD) and ACA adults may be charged Department authorized copayments for certain services performed in an office or home setting, pharmacy services, emergency room visits and inpatient/outpatient services.

Certain services and groups of individuals are not subject to copayments.

The following **services** are exempt from copayments:

- 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 professionals or hospitals made solely for radiology or laboratory services
- Family Planning services
- Speech therapy, occupational therapy, physical therapy
- Audiology services

- Durable medical equipment or supplies
- Medical transportation
- Eyeglasses or corrective lenses
- Hospice services
- Long term care services
- Case management services
- Preventive or diagnostic services
- Renal dialysis treatment
- Radiation therapy
- Cancer chemotherapy
- Insulin
- Services for which Medicare is the primary payer
- Pharmacy compounded drugs
- Prescriptions (legend drugs) dispensed or administered by a hospital, clinic or physician
- Preventive Services

In addition the following individuals are exempt from copayments:

- Pregnant women, including a postpartum period of 60 days
- Children under the age of 19 covered under Title 19 All Kids Assist
- Hospice patients
- American Indians and Alaskan Natives
- Non-institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections
- Individuals enrolled in the Health Benefits for Persons with Breast or Cervical Cancer Program
- Residents of nursing homes, intermediate care facilities for the developmentally disabled and supportive living facilities
- Residents of a State-certified, State-licensed, or State-contracted residential care program

### 114.1.1 Collection of Copayments

The Department automatically deducts copayment amounts from the provider's reimbursement. When billing the Department, providers should bill their usual and customary charge and **should not** report the copayment on the claim.

Providers are responsible for collecting HFS medical programs' copayments from the participant. Providers may choose not to charge a copayment. However, if copayments are charged the copayment amount cannot exceed the amounts show in Appendix 5.

Federal regulations stipulate that for certain low income individuals, a provider cannot deny services due to the person's inability to pay a copayment. This

requirement applies to participants in the following programs:

- Family Care/All Kids Assist
- Medicaid adults (SPD)
- ACA Adults

This requirement **does not apply** to participants in the following programs:

- All Kids Share
- All Kids Premium Level 1
- All Kids Premium Level 2

Providers may apply their office policies/practices relating to copayments to participants covered under these three programs.

#### **114.1.2 Annual Copayment Maximum**

Under the All Kids Share, All Kids Premium Level 1 and Premium Level 2 plans 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 the receipts to the Department once they have reached their 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 as of a specific date. The MEDI and REV/EDI systems are also updated to reflect that the copayment cap has been reached. Providers are responsible for refunding the family any copayments they collect after the family has reached the annual copayment maximum.

#### **114.2 Medicare Coinsurance 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, Other Payment Sources, for further details.

#### **114.3 Monthly Premiums**

Participants of the All Kids Premium Level 1 and Premium Level 2 plans will have a monthly premium for their coverage. The amount of the monthly premium is based on income, the size of the family and how many children are covered.

#### **114.4 State Chronic Renal Disease Program Participation Fee**

Participants in the [State Chronic Renal Disease 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. The fee 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 Chronic Renal Disease 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 participant under this program 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 paying a participation fee prior to the program paying for eligible services. This is referred to as the patient's participation fee. It is determined by the Department on an annual basis based on the participant's family income and size. The participant is notified of the amount in writing, via a letter from the Department.

#### **114.6 Long Term Care Facility Group Care Credits**

Participants in the Department's Medical Programs who reside in a Long Term Care (LTC) facility may be responsible for payment from their monthly income towards the cost of long term care (LTC) covered services. This payment is referred to as the Group Care Credit. The DHS caseworker determines Group Care Credit for each resident on a monthly basis and notifies the resident of the amount on a Form HFS 2500, Long Term Care/Supportive Living Resource Calculation.

Facilities may charge Medicaid-eligible residents for covered LTC services up to the resident's Group Care Credit for that month. Such charges will be automatically deducted from the amount that would otherwise be paid to the LTC facility by the Department.

An electronic version of the Handbook for Providers of Long Term Care (LTC) Services is not available at this time. For questions regarding Group Care Credits or to request a listing of services covered by the Department's monthly payment to LTCs contact the Bureau of Long Term Care at (217) 782-0545.

#### **114.7 Hospice Patient Group Care Credits**

When a hospice patient resides in a long term care facility (LTC), the hospice must bill the Department for the LTC room and board charge and then reimburse the LTC facility. In this case, the patient's Group Care Credit, as described above, is automatically deducted from the amount that would otherwise be paid to the hospice by the Department. For an explanation of this process, refer to [Chapter K-200, Handbook for Hospice Providers](#).

## 120 Other Payment Sources

The Illinois Department of Healthcare and Family Services is, by federal and State Law, the payer of last resort. In most cases, 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.

It is the provider's responsibility to ascertain from each patient whether there is a third party resource that is available to pay for the services rendered. It is the provider's responsibility for determining the status of a patient's eligibility for third party coverage and benefits prior to submitting charges to the Department. Examples of third party resources include Medicare, railroad retirement and other retirement pension plans, private health insurance, group health insurance, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), and certain court orders.

In general, where identifiable third party resources exist, claims must be submitted to and adjudicated by all liable third party payers before the Department will consider a claim for payment. Refer to the Chapter 200 handbook 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 service provided.

[TPL](#) information can be found when verifying a participant's eligibility through [MEDI](#).

If the provider identifies health insurance coverage that is not shown on the [MEDI](#) eligibility screens, or coverage that 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

### 120.1 Third Party Liability Resource Codes

The [Third Party Liability Code Directory](#) is available on the Department's website. The directory contains an alphabetical listing of insuring organizations and the TPL code assigned to each, as well a numerical listing of the same insuring organizations sorted by TPL code. TPL codes appear in the "Source Code" field found in the TPL section of the participant's [MEDI](#) eligibility record. The code consists of a three digit numeric resource code that may be prefixed with an alphabetic coverage code.

When it is present, the alpha coverage code defines the extent of services covered by the TPL source. The alpha coverage codes and level of coverage denoted are as follows:

### **Group Insurance through Employment**

- A – Comprehensive health insurance, dental insurance, vision insurance
- B – Comprehensive health insurance, dental insurance
- C – Comprehensive health insurance
- D – Basic health insurance (high deductibles, high co-payments, etc.)

### **Individual Insurance**

- E – Comprehensive health insurance
- F – Basic health – policyholder under age 65
- G – Medicare supplement insurance –policyholder over age 65
- H – Limited insurance (Accident only, cancer only, etc.)
- I – Hospital indemnity insurance

**Example:** A participant who is insured under a health plan written by Aetna Life Insurance Company will have the TPL resource code of 001. A prefix alpha “A” code added to the TPL resource code (A001) denotes a comprehensive group health insurance plan that is underwritten by Aetna. The alpha codes are added to the record once the Department has verified the coverage.

#### **120.1.1 Prescription Drug Insurance Coverage**

For drugs, a five digit Pharmacy Benefits Manager (PBM) Code is required. A link to the [PBM/TPL Code Directory](#) is available on the Department’s website. Please enter the five digit PBM code as applicable in the Other Payer ID field in the COB/Other Payment segment in the NCPDP version 5.1 (340-7C). If no PBM is identified, but the insurer is known, please indicate the three digit code for the insurer from the [TPL Code Directory](#).

#### **120.2 Medicare and Medicare Advantage Plans**

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. The Medical Assistance Program complements and supplements Medicare program benefits for participants covered under both Medicare and Medicaid by payment of deductible and coinsurance obligations in some instances and by providing coverage of additional medical services in other instances.

The Medicare Program provides hospital insurance (Part A) and supplementary medical insurance (Part B), collectively known as Original Medicare. Participants

with Original Medicare generally pay for the following out-of-pocket expenses: monthly premiums, annual deductible (fixed dollar amount for health care costs before Medicare pays), and coinsurance (a percentage of the cost of covered services and /or supplies). Original Medicare does not include coverage for prescription drugs. If participants with Original Medicare want drug coverage, they must enroll in a Medicare Prescription Drug Plan (Medicare Part D).

Medicare Advantage Plans (MAPs), known as Medicare Part C, are also available for participants with Medicare Part A and B. These health plan options provide all Medicare Part A and Part B benefits, but are offered by private companies. MAPs may also include Medicare Part D coverage. Medicare sets the rules for and approves all MAPs' plan benefits, and cost-sharing requirements for participants. Participants on MAPs also pay monthly premiums, annual deductibles, and co-insurance amounts. Each plan has its own policies.

MAPs include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans and Special Needs Plans. These plans are also referred to as Medicare Replacement Policies.

### **120.2.1 Claim Submittal – Medicare Crossover Claims (Original Medicare and Medicare Advantage Plans)**

Providers may bill the Department for Medicare co-insurance and deductibles for individuals enrolled in the original Medicare or a Medicare Advantage Plan and Medicaid. The Department will consider Medicare cost-sharing expenses for a participant who is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits. Additional information regarding the QMB program can be found on the [QMB Medicare Savings Programs](#) webpage.

If a claim does not automatically crossover to the Department from the Medicare Administrative Contractor for adjudication, providers must submit claims within the twenty-four (24) month timely filing limit for Medicare crossover claims. Claims for MAPs do not automatically cross over to the Department. Non-institutional providers are required to submit a paper HFS 3797, Medicare Crossover or an 837P and institutional providers are required to submit a paper UB claim form or an 8371. For more information on filing a Medicare crossover claim, refer to the appropriate [Chapter 200](#) handbook for the service/provider type being billed. Prior to submitting the claim, providers should review the Explanation of Medicare Benefits to determine if the participant has co-insurance and deductible expenses. After the claim to Medicare has been adjudicated, the Department's payment policies on services to participants who are QMB and Medicaid eligible are as follows:

- For services covered by Medicare, the amount of the payment made by the Medicare plan is compared to 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 HFS 194-M-2, Remittance Advice as approved, but no payment will be made.

- For services that have been rejected for payment by Medicare, a claim may be submitted to the Department for payment consideration only when the reason for the nonpayment by Medicare is one of the following:
  - The patient was not eligible for Medicare benefits, **or**
  - The service is not covered as a Medicare benefit. In such instances, if the service is covered by the Department, the Department will pay its maximum rate for the service.
- For services covered by Medicare, but not by the Department, the Department will pay 80 percent of the Medicare allowable for only the full amount of Medicare deductible and coinsurance.

**Exception:**

- For drugs and medical supplies provided by a pharmacy or Durable Medical Equipment (DME) provider, and reimbursed by Medicare, the Department's liability for deductible and coinsurance amounts shall be at the full Medicare rate.

### **120.2.2 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 instructions on completing this portion of a claim, refer to [Chapter 200](#) handbook for the specific provider type or service.

### **120.2.3 Medicare – Medicaid Alignment Initiative (MMAI)**

The [Medicare Medicaid Alignment Initiative \(MMAI\)](#) is a joint effort with the federal government to reform the way care is delivered to participants eligible for both Medicare and Medicaid benefits; these participants are referred to as Dual Eligible. A participant's enrollment in the MMAI can be verified on MEDI and REV/EDI under

the “Managed Care Organization” segment. Claims for participants enrolled in the MMAI must be submitted to the appropriate MMAI plan. Additional information on this initiative is available on the [MMAI](#) webpage.

### **120.3 Workers’ Compensation and Personal Injury Cases**

In cases involving a workers’ compensation or automobile accident/personal injury claim, the provider must decide up front whether to submit a claim to the Department or to the other carrier. By electing to submit the claim to the Department, the provider is agreeing to accept the payment from the Department as payment in full. If the provider elects not to bill the Department, once the 180 day timely filing has passed, the Department cannot be billed. In making the decision to bill the Department first, the provider should be cognizant of the possibility that the third party payer 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 third party payer is permitted. In all other cases involving third party payers, the provider must bill the other payer before billing the Department.

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 request **pertaining to Cook County and out-of-state residents** to:

[Illinois Department of Healthcare and Family Services](#)  
Technical Recovery Unit  
32 W. Randolph, 13<sup>th</sup> Floor  
Chicago, Illinois 60601

Address requests for all other Illinois residents to:

[Illinois Department of Healthcare and Family Services](#)  
Technical Recovery Unit  
201 South Grand Avenue East  
Springfield, Illinois 62763-0001

### **120.4 Exception for Billing Other Payment Sources for Preventive Services for Children and Pregnant Women**

Practitioners providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a participant’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 payer 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 third party payer is permitted.

## 130 Payment Process Overview

No attempt will be made by the Department to process unacceptable claim forms, photocopies, forms other than those supplied or specifically approved by the Department, and illegible forms.

The Department does not accept the CMS 1500 claim form for processing. If the Department receives a CMS 1500, it will not be processed or returned.

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.

To be eligible for reimbursement, providers and suppliers must submit claims to the Department within a qualifying time limit. A claim will be considered for payment only if it is received by the Department no later than 180 days from the date on which service or item is provided. This time limit applies to both initial and resubmitted claims. Initial or resubmitted claims received more than 180 days from the date of service will not be paid. For more information regarding the 180 day time limit and certain exceptions refer to Topic 112.

### 130.1 Payment

Payments are made in accordance with Department standards and rates for the services(s) provided. Payment will be made by a State warrant (check) issued through, and mailed by, the Illinois Office of the Comptroller, or via direct deposit/EFT. Remittance advices are sent in a separate mailing handled by the Department. The X12 835 Electronic Remittance Advice (ERA) can be accessed through MEDI or through a vendor.

Information on the issuance of warrants can be obtained on the [State of Illinois Comptroller's](#) website.

#### 130.1.1 Designation of Pay-to Provider (Payee)

At the time of initial enrollment with the Department, a provider must designate its pay-to provider(s) when registering in [IMPACT](#). Refer to Topic 101 for more information on IMPACT. Certain types of providers also may designate alternate pay-to providers. Information specifying conditions under which a group practice or an institution may be designated as pay-to provider is included in materials issued to providers upon enrollment for participation. If a provider has more than one pay-to provider listed with the Department, each claim submitted for payment must specify the pay-to provider to which the warrant and remittance advice is to be mailed.

Changes in pay-to provider designation or addresses are to be submitted to the Department via [IMPACT](#) as they occur, to ensure that warrants are sent to the correct pay-to provider and address.

Since 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.

### **130.1.2 Direct Deposit — Electronic Funds Transfer (EFT)**

The direct deposit/EFT option allows providers to have payments electronically deposited into their bank account. Direct deposit/EFT must be requested by the pay-to provider of record, not by the rendering provider. All pay-to providers (payees) receive a paper remittance advice for medical payments, even if they choose to receive payments electronically. Direct deposit/EFT can be arranged by contacting the [Illinois Office of the Comptroller \(IOC\)](#).

The IOC **will not** pay any voucher under \$5.00 except through direct deposit/EFT. No paper warrants will be generated. The IOC will reject any voucher that is less than \$5.00 when the provider/vendor is not registered for direct deposit/EFT on the IOC system. Pay-to providers (payees) not using direct deposit/EFT will receive paper warrants through the mail for vouchers in an amount greater than \$5.00.

### **130.2 Remittance Advice**

The Department mails a [Form HFS 194-M-2, Remittance Advice](#) for each warrant issued to a pay-to provider by the Office of the Comptroller. The remittance advice reports the status of claims and adjustments processed. See General Appendix 3 of this handbook for an explanation of the information that appears on the remittance advice.

Receipt of the remittance advice from the Department does not constitute immediate payment by the IOC. Normal payment parameters are enforced. The Department does not hold remittance advices that are awaiting payment by the IOC. Medical Assistance providers should retain these remittance advices as payments are issued and mailed separately by the IOC.

The ANSI v5010 835 electronic Remittance Advice (ERA) is available to the designated and registered payee on the MEDI/IEC website for a maximum period of 60 calendar days after release of payment by the IOC.

### **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-2, Remittance Advice, with the specific error code(s) that rendered it unpayable or on the ASC X12 835, Health Care Payment /Remittance Advice (ERA), with specific Claim Adjustment Reason Codes (CARCs) or Remittance Advice Remark Codes (RARCs). Additional information on CARCs and RARCs can be found in Chapter 22 of the [Medicare Claims Processing Manual](#). A rejected service will be considered for payment only if all errors can be and are corrected and the corrected claim is resubmitted within the timely filing limit. To be considered timely, the corrected claim must be received by the Department within 180 days of the date of service, or within the timely filing period specified for claims that meet one of the exceptions to the timely filing rule. For an explanation of the error code(s) and the possible corrective action to be taken prior to contacting the Department, please refer to the [Claims Processing Error Code Listing](#) available on the HFS website.

In addition to verifying all information on the claim, it is important for the provider to verify the participant's eligibility prior to submitting a claim to the Department. If a participant is not eligible on the date the service is rendered, the claim cannot be paid or rebilled unless eligibility is determined and backdated to the date of service. In this situation the claim is considered timely if it is received by the Department within 180 days of the system update on eligibility. Refer to Topic 131, Billing Inquiry Process, 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 action by the Department will be temporarily suspended. If any service section on a claim form requires special handling or action by the Department, the entire claim will be suspended until the claim can be adjudicated. These claims will be reported on the [HFS 194-M-2, Remittance Advice](#), as suspended. Services listed on claims that have been suspended are not to be rebilled. The suspended claim will appear on a later remittance advice when all the services billed have been adjudicated as either paid or rejected.

#### **130.5 Paper Claim Certification**

All paper claim forms 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 on the claim. Please refer to Topic 112.7.1 for additional information on certifying paper claims.

#### **130.6 Electronic Claim Certification**

Electronic claims and claims created by the Department do not contain a certification statement, 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.

Each remittance advice that reports an electronically submitted claim or a claim created by the Department will be accompanied by a Form HFS 194-M-C, Billing Certification. It is the responsibility of the provider who rendered the service to review the remittance advice and attest to the accuracy of the information by signing the billing certification form.

The same signature requirements that apply to the signing of a paper claim, as described in Topic 112.7.1, 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 Law, whichever is longer.

### **130.7 Overpayment Disclosure**

As a result of Public Act 097-0689, referred to as the Save Medicaid Access and Resources Together (SMART) Act, the Department is required to establish a protocol to enable health care providers to disclose an actual or potential violation of Medical Assistance (Medicaid) program requirements. The Department's Office of Inspector General's (OIG) "Provider Self-Disclosure Protocol," (refer to Appendix 7) establishes a voluntary disclosure process that providers may utilize upon detection of receipt of an overpayment from the Department. The self-disclosure protocol will also assist providers in complying with overpayment detection and repayment obligations under the federal Patient Protection and Affordable Care Act (ACA).

The self-disclosure protocol is intended to establish a fair, reasonable, and consistent process that is beneficial for both the Department and the disclosing provider. The OIG recognizes that the situations that are appropriate for referral to the protocol will vary significantly; therefore, the protocol is written in general terms to allow providers and the OIG the flexibility to address the unique aspects of each situation. Each disclosure will be reviewed, assessed, and verified by the Department on an individual basis.

In exchange for the provider's good-faith self-disclosure and ongoing cooperation, the Department may offer benefits to the provider. These benefits may include the waiver or reduction of interest payable on an overpayment, extended repayment terms, and waiver of some or all applicable penalties or sanctions.

## 131 Billing Inquiry Process

Situations may arise when a provider finds it necessary to contact the Department regarding how to bill claims or reimbursement. Providers are reminded to first check the [Chapter 200](#) handbook and/or appendices specific to the provider type/service billed 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 Inquiries

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 with a billing inquiry:

- Patient's name and Recipient Identification Number (RIN)
- 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

Written inquiries are to be mailed separately from claims. Do not mail billing inquiries in the pre-addressed envelopes provided by the Department for mailing claims and other claim specific related forms. Refer to the Foreword of this handbook for contact information.

### 131.2 Claim Status Verification

Claim status verifications are not available by phone or mail. There are several electronic methods through which providers can check the status of claims. With any of these methods, it will take seven days from the date of submission for a claim to register within HFS' claim status system. Failing to wait the seven days prior to making an inquiry will return incomplete information. Due to the volume of claims processed by the Department, this information is only available for two years from the date of the voucher/warrant. The following outlines the automated electronic methods available to providers to use for claim status verification.

#### [Medical Electronic Data Interchange \(MEDI\) Authorization System](#)

The Department provides the Internet Electronic Claims (IEC) System to handle the electronic transfer of HIPAA-compliant formats, to meet the requirements of HIPAA. To use the IEC System, you must complete MEDI Registration and Authorization. Visit the [MEDI Getting Started](#) webpage for additional information.

The main purpose of the IEC System is to provide registered [MEDI](#) users the ability to perform basic processing, including verifying eligibility, verifying the status of a claim and submitting claims.

The Direct Data Entry (DDE) inquiry provides an immediate single claim status response for up to 90 days from the Date of Voucher for NIPS/Pharmacy claims and 180 days for institutional claims. Requests for status information on older voucher dates must be accessed using the batch inquiry HIPAA 276 transaction.

The batch inquiry capability allows providers to perform either a single inquiry for a claim not meeting the DDE date criteria above or to perform an inquiry for multiple claims in one batch. Batch inquiries are processed overnight and the HIPAA 277 transaction responses are available on the [MEDI – IEC](#) website the next business day. It is the provider's responsibility to access the website and download the 277 transaction. Please submit only one batch file per day with a limit of 5,000 inquiries per transaction set (ST/SE).

Please note that the HIPAA 277 transactions will contain only the HIPAA defined response codes and associated messages. The Department's proprietary error messages used on the HFS 194-M-2 Remittance Advice will not be displayed. Visit the [Washington Publishing Company-WPC](#) website to obtain the latest descriptions for the HIPAA Reason and Remark Codes.

### **[Recipient Eligibility Verification \(REV\) System](#)**

Some of the Department's REV vendors have electronic systems that provide claim status information to their provider customers. All current REV vendors also act as clearinghouses for other public and private payers. In this role, REV vendors may offer services beyond those related to the Department's programs. For example, a REV vendor may offer general computer accounting support, preliminary claim editing, accounts receivable posting or claims submittal to third party payers. Providers pay the REV vendors for whatever mix and volume of services selected. Providers are encouraged to contact REV vendors to determine which vendor best meets their needs.

### **[Electronic Data Interchange \(EDI\) Service](#) Trading Partners**

The Department is currently developing the Electronic Data Interchange (EDI) Service. This service will eventually replace the Recipient Eligibility Verification System. Many of the same services offered through REV will be available through the Department approved EDI trading partners. Providers will be notified when this change occurs.

## 132 Adjustments

Adjustments 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 [Form HFS 194-M-2, 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 if a correction to the payment is needed.

Adjustment forms are available on the Department's [Medical Programs Forms](#) webpage and instructions for their completion are provided in General Appendix 2 of this handbook.

The Department will also accept an 837 transaction to void or replace a payable or pending-payable claim. Providers can void a single service line or an entire claim. For additional information refer to [Chapter 300 Companion Guide](#).

If the error is due to a computer problem in the Department's data system, the Department may initiate the adjustment. 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 through the point-of-sale billing system, and submitted within the previous two years must be adjusted electronically via the Department's point-of-sale system, using the appropriate National Council of Prescription Drug Programs (NCPDP) protocol. The adjusted transaction can be followed by the submission of a new claim reflecting the correct information provided it is submitted within the 180 day timely filing window.

Services requiring adjustments that cannot be submitted electronically must be submitted on a paper Pharmacy Adjustment Form (HFS 1040) as a void transaction along with a cover sheet containing the name and phone number of an individual that can be contacted should the need arise. Examples of services that cannot be submitted electronically include, but are not limited to;

- Transactions beyond 2 years old
- Claims that have been submitted via the Department's Medical Electronic Data Interchange (MEDI) application,
- Services submitted on paper claim forms

The void transaction can be followed by the submission of a new invoice reflecting the correct claim information, if the new bill is submitted within the 180 day timely filing window.

### 132.2 Long Term Care (LTC) Facility Adjustments

**For dates of service prior to 12/01/2016**, LTC facilities do not complete adjustment forms for incorrect payments made for LTC services. The Department initiates adjustments on a monthly basis to reflect corrected or changed information that may alter payment amounts.

**For dates of service on or after 12/01/2016**, LTC facilities will submit a [Form HFS 2249 Adjustment \(Hospital\)](#) to the Department to void a previously adjudicated claim for LTC services. Detailed information on the void and rebill process for LTC facilities, including an example of a completed Form HFS 2249, can be found on the [Long Term Care Direct Billing Resources](#) webpage on the Department's website.

If a LTC facility bills the Department directly as a durable medical equipment provider for a non-long term care service, such as supplemental oxygen, and is paid an incorrect amount, such claims must be adjusted using the process in place for that provider type.

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 or discharge.

## 133 Refund/Returned Checks

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

For all provider types, except Long Term Care Facilities, if questions arise about the refund process, the required documentation is not available, or 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.

### 133.1 Refund/Returned Check Process

To ensure that the Department has all of the information necessary for processing a refund or returned check and adjusting the provider's claims history file, the following process should be followed:

- Appropriate adjustment form must be submitted with the refund/returned check. Refer to General Appendix 2 for instructions on completing adjustment forms.
- A copy of the remittance advice associated with the incorrect or overpayment must be submitted with the refund/returned check. The remittance advice should be marked to clearly indicate which payment is being refunded.
- The provider must ensure that the total of all the individual service adjustments equals the refund/returned check amount. Confirmation of the Department's receipt of the refund/returned check 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.
- Do not include payment refunds for various provider types/services on one check, e.g., hospital and non-institutional services. Separate checks are required because the refunds are processed in two separate systems.
- Refund/returned checks should be mailed to:

- **For services billed on the UB-04**

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

- **For pharmacy services**

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

- **For Non-Institutional Provider services**

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

- **For Third Party Liability (TPL) refund checks**

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

The [Office of Inspector General \(OIG\)](#) for the Illinois Department of Healthcare and Family Services has statutory authority to oversee the integrity of the Illinois Medical Assistance Program (Program), in order to prevent, detect and eliminate fraud, waste and abuse. Pursuant to this authority, the OIG performs pre-payment and post-payment audits of providers to ensure that appropriate payments are made for services rendered and to prevent and recover overpayments. Through these audits, the OIG ensures compliance with State and federal law and Department policy.

The OIG approaches auditing using various audit methodologies. These audit methodologies are tailored to identify the risk of loss, based on changing trends. All Medicaid providers are subject to audit and are periodically reviewed. The selection of a provider for audit review is based on a number of factors, including but not limited to: data analysis; external complaints of potential fraud or improper billing; and provider risk scores and categories.

Audits are an important and necessary part of the Department's program integrity monitoring for health care facilities and services, and are required by federal and Illinois law. 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 must cooperate and furnish to the Department, or to its authorized designee, pertinent information regarding claims for payment. Each provider is responsible for maintaining complete records that substantiate the payments received and billed, in accordance with the Department's [provider handbooks](#), [administrative rules](#), federal and State laws and regulations. The Inspector General has the authority to deny or suspend payment to, and deny, terminate, or suspend the eligibility of, any provider who fails to grant the Inspector General timely access to full and complete records, including records of participants under the Medical Assistance Program for the most recent six (6) years, in accordance with [Section 140.28 of Title 89 of the Illinois Administrative Code](#), and other information for the purpose of audit, investigation, or other program integrity functions, after reasonable written request by the Inspector General. Generally, the audit review process involves:

- An initial interview and initial document review.
- A preliminary exit conference to discuss preliminary audit findings.
- An opportunity for the provider to dispute any preliminary audit finding(s) and submit additional documentation within 21 calendar days from the date of the preliminary exit conference.
- An audit post preliminary exit conference.
- A final exit conference to discuss the final audit determination.

- The right to file an appeal within sixty (60) calendar days from the date of the final audit determination letter to notify the OIG in writing of its intent to appeal any disputed audit overpayment amount.

The provider must identify the total amount of all undisputed and disputed audit overpayment. Any undisputed audit overpayment amount will constitute a final audit overpayment determination. The provider has sixty (60) calendar days from the final audit determination letter to report, explain and repay any overpayment, pursuant to [42 U.S.C.A. Section 1320a-7k\(d\)](#) and [Illinois Public Aid Code 305 ILCS 5/12-4.25\(L\)](#). The OIG will forward the appeal request pertaining to all disputed audit overpayments to the Office of Counsel to the Inspector General for resolution.

The provider will have the opportunity to appeal the Final Audit Determination, pursuant to the hearing process established by 89 Illinois Adm. Code, [Sections 104 and 140.1 et. seq.](#)

In appropriate circumstances, the OIG will impose sanctions on non-compliant providers. Providers may be subject to the Department's sanction authority, including but not limited to payment suspension, payment denial, monetary penalties, and termination or exclusion from participation the program. See [Illinois Public Aid Code at 305 ILCS 5/12-4.25](#) and [89 Illinois Administrative Code, Part 140, Subpart B.](#)

Common audit methodologies used by the OIG in identifying and recovering overpayments are as follows:

**Desk Audits:** This methodology employs algorithms that analyze specific program billing and reimbursement data that can be validated. In a desk audit, claim data elements and established law and policy are used to determine if an overpayment was made. The overpayment amounts are verified through analytical methods.

**Field Audits:** This methodology employs algorithms that analyze specific program billing and reimbursement data that cannot be automatically validated. Field audits therefore require a manual review of medical or other documentation by audit reviewers or other qualified professionals

**Self-Audits and Self Disclosure:** Where the OIG identifies an irregularity in the billing practices of a provider, the OIG may request that the provider conduct its own investigation and overpayment self-disclosure. The provider has 60 days from Department notification to report, explain and repay any overpayment, pursuant to [42 U.S.C. A. Section 1320a-7k\(d\)](#) and [Illinois Public Aid Code 305 ILCS 5/12-4.25\(L\)](#).

### 134.1 Sampling and Extrapolation

Department audits may involve the use of sampling and extrapolation. Audit sampling is the application of an audit procedure to less than 100 percent of the claims in an audit universe. Under this procedure, the Department selects a statistically valid sample of the claims during the audit period in question and audits the provider's records for those claims. The Department uses random sampling to estimate the parameters of a population, in order to measure and control sampling risk. Through the use of random sampling, every member of the population (claim) is equally likely to be in the sample. Random sampling allows the Department to achieve statistical validity and ensures that the sample represents the entire population of claims.

All overpayments determined by an audit of the claims in the sample are totaled and extrapolated to the entire universe of claims during the audit period. The provider must pay the Department the entire extrapolated amount of overpayments calculated under this procedure after notice and opportunity for a hearing, pursuant to [89. III. Adm. Code 104.210](#).

### 134.2 Payment Suspensions

In certain instances, State and federal laws require the OIG to place a suspension on a provider's payment. Under the Affordable Care Act (ACA), the State must place a payment suspension when there is a credible allegation of fraud. For more information concerning payment suspensions and circumstances under which the OIG may release payment suspensions, see 89 III. Adm. Code [104.72-74](#) and [140.44](#) and Topic 135, Recoupment Resulting From Audits, of this handbook.

## 135 Recoupment Resulting From Audits

The Department may recover money improperly or erroneously paid, or overpayments, either by setoff, crediting against future billings or by requiring direct repayment to the Department. The Department may suspend or deny payment, in whole or in part, if such payment would be improper or erroneous or would otherwise result in overpayment.

Providers must repay an overpayment within sixty (60) calendar days pursuant to [42 U.S.C.A. Section 1320a-7k\(d\)](#) and [Illinois Public Aid Code 305 ILCL 5/12-4.25\(L\)](#). If a provider disputes the audit determination, the provider has the right to appeal, pursuant to the hearing process established at 89 Illinois Administrative Code, [Part 104](#) and [Part 140](#). Providers must notify HFS-OIG of intent to appeal by making a written request for a hearing, identifying each disputed and undisputed overpayment amount, and briefly identifying the basis for contesting the recover.

The provider receives written notification of the finding. If the provider remains in disagreement with the Department actions with respect to the audit, within ten (10) days of receipt of the written notification, they may 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.

Payments may be denied, recovered or suspended from a provider or alternate pay-to provider for any of the following reasons:

- For services rendered in violation of the Department's provider notices, statutes, rules, and regulations.
- For services rendered in violation of the terms and conditions prescribed by the Department in its provider agreement (see [Provider Enrollment Terms & Conditions](#)).
- For any provider who fails to grant the Office of Inspector General timely access to full and complete records, including, but not limited to, records relating to participants under the Medical Assistance Program for the most recent 6 years, in accordance with [89 Illinois Adm. Code, Section 140.28](#), and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General; this subsection (E) does not require providers to make available the medical records of patients for whom services are not reimbursed under this Code or to provide access to medical records more than 6 years old.

- When the provider has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Medical Assistance Program; or when the provider rendered services while terminated, suspended, or while terminated or excluded from participation in another state or federal medical assistance or health care program.

The determination of an overpayment will be based on federal and Illinois law, administrative rules, and Department policy and procedures as stated in the applicable provider handbooks or as evidenced by data on program utilization compiled from claims paid.

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.

## 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 monitors all claims to identify suspicious activities and providers suspected of fraud will be criminally investigated and, when appropriate, prosecuted in state or federal court.

Title XIX of the Social Security Act, under which the Medical Assistance Program is administered, provides federal penalties for fraudulent acts and false reporting. In addition to administrative and civil remedies, providers are subject to State and federal laws pertaining to penalties for provider fraud and kickbacks ([Illinois Public Aid Code 305 ILCS 5/8A-3](#)). Program participants, providers or other individuals who have information regarding possible fraud or abuse should call the Medicaid/Welfare Fraud Hotline, at 844-453-7283/844-ILFRAUD.

Providers suspected of fraud, waste, or abuse shall be subject to the Department's sanction authority, including but not limited to payment suspension, payment denial, monetary penalties, and termination or exclusion from participation in the program. See [Illinois Public Aid Code at 305 ILCS 5/12-4.25](#) and [89 Illinois Administrative Code, Part 140, Subpart B](#). The Department defines fraud, abuse, waste, harm and credible allegation in the following manner.

**Fraud:** Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or State law.

**Abuse:** Means provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to the Medical Assistance Program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes participant practices that result in unnecessary cost to the Medical Assistance Program. Abuse does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible provider liability.

**Waste:** Means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the Medical Assistance Program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible provider liability.

**Harm:** Means physical, mental, or monetary damage to participants or to the Medical Assistance Program.

**Credible allegation:** Is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims date mining, patterns identified through provider audits, civil actions filed under the Illinois False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

## 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. Written information must be given 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 Manage 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
  - 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.
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
- Managed Care Organizations — at the time of enrollment of the individual with the MCO

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 advance directive 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 directive, 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 patient is incapacitated or otherwise unable to receive information or articulate whether he or when has exacted an advance directive, the facility must note that the individual was not able to receive information and was unable to communicate whether an advance directive existed.