

Illinois Department of Healthcare and Family Services

Federally Qualified Health Centers (FQHC)

Rural Health Centers (RHC)

Encounter Rate Clinics (ERC)

Billing Webinar

August 18, 2016



What's New at HFS?



- IMPACT Updates
- Postpartum Visits and Perinatal Care Transition
- Prior Approval for Children's Physical and Occupational Therapy Services
- Revision of Form HFS 1409 Prior Approval Request and Availability
- Health Alliance Medicare-Medicaid Alignment Initiative (MMAI)
- Care Coordination Health Plan Transitions for ACE and CCE Enrollees
- Managed Care Manual
- Publication of Public Notices on Healthcare and Family Services Website
- Change to Procedure Code for billing Emergency Contraceptive Pills (ECPs)
- Handbook Updates

IMPACT

Enhancement to Allow The Provider to Enter A Remittance Address

- Please refer to the October 28, 2015 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151028a.aspx>
- Beginning December 12, 2015 the Enrollment system was modified allowing enrollment of **Typical or Atypical** Sole Proprietor, Group, Facility/Agency/Organization(FAO) or Atypical Agency with multiple NPI's (National Provider Identifiers) to enter an optional address termed the **Remittance Address**
- If a **Remittance Address** was not entered, then the provider's payments and remittance advices were directed to the Pay to Address listed for that TIN
- It is also important to note that there is only one Remittance Address per IMPACT enrollment no matter the number of locations listed in that enrollment
- The IMPACT Remittance Advice modification allowed providers using one TIN, but having multiple NPI's, to have their own address for the routing of payments and remittance advices
- Providers had previously been informed that the Pay To Address in IMPACT would be used to update all Legacy Payees with the same TIN; however, this did not happen until after January 1, 2016

IMPACT

Provider Revalidation Due Date Extensions

- Please refer to the March 15, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160315a.aspx>
- The Center for Medicare and Medicaid Services (CMS) has extended the revalidation due date for all Medicaid Providers to revalidate to September 24, 2016
- Facility/Agency/Organizations (FOAs) revalidation was extended to June 30, 2016
- HFS further extended the revalidation due date for Individual/Sole provider to August 31, 2016
- Failure to submit a provider's enrollment for revalidation and approval will result in disenrollment from Illinois Medicaid on September 25, 2016. ***All providers are encouraged to revalidate as soon as possible to ensure their application is approved by the due date.***

IMPACT

Provider Type Selections

- Please refer to the May 13, 2016 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513a.aspx>, which reminded providers to select **ALL** correct Specialty/Subspecialty combinations upon completion of the initial application or revalidation in the IMPACT system.
- It is important to select the correct specialty, and subspecialties if applicable, in order to be reimbursed for all categories of services currently provided to Medicaid participants
- Claims that are submitted with information that is different from the most recent Provider Information Sheet may be delayed in processing or rejected
- Separate applications have been completed by providers for each specialty/subspecialty causing the system to generate additional provider ID numbers resulting in rejections of claims because the system does not recognize them
- A table of IMPACT Provider Types, Specialties and Subspecialties may be found on the [IMPACT website](#), which also provides important information for providers who may have questions regarding these issues

IMPACT

Provider Enrollment Data Exchange

- Please refer to the May 13, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513b.aspx>
regarding the transferring of data from the IMPACT enrollment system into the system that processes provider claims known as the Legacy Medicaid Management Information System (MMIS)
- Provider Information Sheets are mailed to providers at the office address on file and to all “payee addresses” if different from the office address
- Providers are responsible for reviewing all information for accuracy or risk a delay in claim processing or rejections
- It is critical for payment of claims that the provider name matches the “Doing Business As” name in IMPACT
- Do not change the historical provider name submitted on claims to match the “Doing Business As” name in IMPACT until you have received the provider information sheet from HFS

IMPACT

New Rendering/Servicing Provider

- Please refer to the July 11, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160711a.aspx>
- Once the revalidation process has been completed, new rendering/servicing providers will be required to enroll in IMPACT whom have not been previously required to enroll. This includes Physician Assistants and any previously non-enrolled APNs.
- The Department will notify providers when these types of rendering/servicing providers need to begin the enrollment process via a provider notice posted on the IMPACT website
- For additional information, including frequently asked questions, webinars and other training guides, please visit the [IMPACT website](#)

IMPACT

Claims Processing for New and Revalidating Providers

- Please refer to the June 23, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160623b.aspx>
- Although new providers whose enrollment has been approved in IMPACT will receive an email welcoming them as a Medical Assistance Provider, information from the IMPACT enrollment system must be transferred to the legacy system (MMIS) prior to billing. This could take up to two weeks.
- Once the Department has transferred data from the IMPACT system to the legacy system (MMIS), a Provider Information Sheet will be generated and sent to the Pay to Address
- Prior to billing, providers should review the Provider Information Sheet to verify that everything is correct. If correct, claims may then be submitted.
- Providers must request a time override for any claims that are past the timely filing limit. ***Only the claims that could not be billed until the following were completed: enrollment, re-enrollment, addition of a new specialty and/or sub-specialty, or a payee addition, are eligible for a time override of 180 days from the update recorded on the provider file.*** For instructions on how to request a time override please refer to the Timely Filing Override Submittal instructions found at:
<http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx>.
- If you have additional questions or need assistance, please contact the IMPACT Help Desk:
 - By email: IMPACT.Help@Illinois.gov
 - By phone: (877) 782-5565 Select option #1

Postpartum Visits and Perinatal Care Transitions

- Please refer to the September 29, 2015 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150929a.aspx>
- Care transition is the movement of patients from one health care practitioner or setting to another provider as their condition and care needs change, ensuring coordination and continuity of care
- The postpartum visit should be scheduled or confirmed prior to hospital discharge and discharge instructions should include the appointment date, time and location
- The postpartum visit allows for a physical exam, supportive guidance on healthy behaviors, assessment of health conditions, including depression, preconception counseling, and reproductive life planning, including discussion/initiation of birth control, if not previously initiated
- Reimbursement is allowed for one comprehensive postpartum visit with additional visits for related issues outside the routine postpartum visit, which are payable if supported with appropriate coding/documentation
- The postpartum provider should ensure that women are linked back to their primary care provider (PCP) after the postpartum visit which is especially important if the patient has other medical conditions, complications during pregnancy, or pre-existing co-morbidities
- If the PCP is unknown please review the “Quick Reference Tool” link provided as an attachment to the Provider Notice in identifying the patient’s PCP

Prior Approval for Children's Physical and Occupational Therapy Services

- Please refer to the November 23, 2015 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151023b.aspx>
- As a result of Public Act 098-0651, the Department is required to prior approve **all adult and child therapy services** for medical necessity
- The Department implemented prior approval for medical necessity of physical and occupational therapy for children through age 20 effective with dates of service on or after November 16, 2015
- Home health agencies must submit the following information for each prior approval:
 - HFS 1409 (pdf) Prior Approval Request Form
 - Practitioner Order
 - Therapist Initial Evaluation
 - HCFA 485 Plan of Care
- Outpatient therapy providers must submit the following information for each prior approval:
 - HFS 3701T (pdf) Therapy Prior Approval Request Form
 - Practitioner Order
 - Therapist Initial Evaluation
 - Plan of Care

*Initial Requests and renewal requests may be faxed to (217) 524-0099

**Reviews and additional information may be faxed to (217) 558-4359

Prior Approval for Children's Physical and Occupational Therapy Services (cont'd)

- ▶ Children age birth to three may be eligible to receive their physical and/or occupational therapy services through the Illinois Early Intervention (EI) Program, administered by the Department of Human Services
- ▶ Developmental screening should first be conducted by the medical provider at priority intervals at the 9 month and 18 month visit, and the 24 month and/or 30 month visit. Further guidance regarding objective developmental screenings is in Section HK-203.5 of the Handbook for Providers of Healthy Kids Services at:
<http://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf>
- ▶ Screening tools can be found in the appendices in the Handbook for Providers of Healthy Kids Services at:
<http://www.illinois.gov/hfs/SiteCollectionDocuments/hk200a.pdf>

Revision of Form HFS 1409 Prior Approval Request

- The Department has recently reformatted the HFS 1409 Prior Approval Request Form. There are no changes to the content of the form.
- The new version is available in a PDF-fillable format on the Medical Forms Page at:
<http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx>
- The Department no longer stocks a paper version for ordering from the warehouse. Providers must print the form from the website for submission.
- Please refer to the January 26, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160126a.aspx>

Care Coordination

- ▶ The transition of all participants who were enrolled in ACEs and CCEs to other plans has been completed
- ▶ The Department will be updating Medicaid-Medicare Alignment Initiative (MMAI) information

Managed Care Manual

- Please refer to the January 19, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160119a.aspx>
- A link to the manual is provided in the notice
- The manual contains information regarding the Medicaid Managed Care Program and is not intended to supersede, modify or replace any policies, guidelines, or other provider handbooks applicable to providers in the Medical Assistance Program under the fee-for-service payment system

Publication of Public Notices on HFS Website

- Please refer to the March 18, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160318b.aspx>
- The Centers for Medicare and Medicaid Services (CMS) published final rules designed to ensure that States' fee-for-service Medicaid payments comply with the access standards outlined in Section 1902(a)(30)(A) of the Social Security Act (SSA)
- This new rule recognizes electronic publications posted on the Medicaid state agency's web site as an acceptable form of public notice
- The Department has developed a webpage on the HFS web site for the purpose of providing public notice of proposed changes in methods and standards for setting payment rates for services. A link to the public notices can be found under the "Stay Informed" section located at the bottom left hand corner of the HFS Home Page at: <http://www.illinois.gov/hfs/Pages/default.aspx>

Change to Procedure Code for Billing of Emergency Contraceptive Pills (ECPs)

- ▶ Please refer to the April 29, 2016 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160429a.aspx>
- ▶ Effective with dates of service June 1, 2016 all emergency contraceptive pills (ECPs) must be billed using procedure code J8499
- ▶ Effective with dates of service June 1, 2016 the Department will no longer reimburse ECPs billed with procedure code S4993

Handbook Updates



- ▶ Chapter E-200, Audiology Handbook – reissued May 2016
- ▶ Chapter B-200, Chiropractor Handbook – reissue COMING SOON
- ▶ Chapter L-200, Handbook for Laboratory Services – reissued May 2016
- ▶ Chapter F-200, Podiatry Handbook – reissue COMING SOON
- ▶ Chapter A-200, Practitioner Handbook – reissue COMING SOON
- ▶ Chapter J-200, Therapy Services Handbook – reissued July 2016
- ▶ Chapter D-200, Encounter Clinic Services Handbook - reissued August 2016

ICD - 10

- Please refer to the June 17, 2015 provider notice concerning the ICD-10 Implementation – Claim Submission Requirements which includes FAQs at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150617a.aspx>, with a reminder follow up notice dated October 5, 2015 at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151005a.aspx>
- The conversion from ICD-9-CM code set to ICD-10-CM code set as federally mandated was effective October 1, 2015
- HFS will reject claims that are billed with both ICD-9-CM and ICD-10-CM diagnosis codes on the same claim
- HFS will reject claims billed with ICD-9-CM diagnosis codes and service dates on or after October 1, 2015
- The Department has revised the following paper claim forms to accommodate ICD-10-CM diagnosis coding. There is a revision date of **R-2-15** in the bottom left corner of the form.
 - HFS 2210 – medical equipment/supplies
 - HFS 2211 – Laboratory/Portable X-ray
 - HFS 2212 – Health Agency

Senate Bill 741

Medicaid Benefit Changes

- Details may be found on the HFS website at:
<http://www.illinois.gov/hfs/info/factsfigures/Pages/SB741FactSheet.aspx> Please note that not all Senate Bill 741 changes apply to encounter clinic billing.
- Restoration of coverage for adult dental care services to that prior to the SMART Act effective July 1, 2014
- Restoration of coverage for adult podiatry services effective October 1, 2014. Coverage for podiatry services for adults is no longer limited to participants with a primary diagnosis of diabetes.
- Elimination of the prior authorization requirement under the four prescription policy for anti-psychotic drugs effective July 1, 2014
- Elimination of the prior authorization requirement under the four prescription policy for children with complex medical needs who are enrolled in CCE solely to coordinate care for these children, if the CCE has a comprehensive drug reconciliation program, effective July 1, 2014
- Elimination of the annual 20 visit limit for speech, occupational and physical therapies effective October 1, 2014
- Prior approval is required for all participants for occupational and physical therapies, as well as speech therapy for adults. Speech therapy for children will require prior approval at a later date.
- Speech for children does not require prior approval through the age of 20

Tobacco Cessation Counseling Services



- Please refer to the August 26, 2014 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140826a.aspx>
- Tobacco cessation counseling services for eligible participants may be billable as detail codes using the following procedure codes when billed with the T1015 encounter code:
 - 99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
 - 99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
- Counseling sessions must be provided by, or under the supervision of, a physician or any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services

Tobacco Cessation Counseling Services (cont'd)

Duration of Counseling

- For pregnant and up to 60-day post-partum women age 21 and over
 - A maximum of three quit attempts per calendar year
 - Up to four individual face-to-face counseling sessions per quit attempt
 - The 12 maximum counseling sessions include any combination of the two procedure codes identified in the previous slide
- Children through age 20 are not restricted to the maximum twelve counseling sessions

Tobacco Cessation Counseling Services (cont'd)

Pharmacotherapy

- The Department covers nicotine replacement therapy in multiple forms, as well as two prescription medications indicated for use as an aid to smoking cessation
- Please refer to the Drug Prior Approval webpage for specific drug coverage and prior approval requirements. This link may be found at:
<http://ilpriorauth.com/>
- Nicotine replacement duration of therapy is normally limited to three months in a year; however, duration limitations may be overridden by the Department through the prior approval process on an individual patient basis
- To request prior approval for a specific drug please refer to the link at:
<http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/DrugPriorApprovalInformation.aspx>

Adult Dental Coverage



- Please refer to the June 26, 2014 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140627a.aspx>
- Effective July 1, 2014, coverage for adult dental services was restored to that prior to the SMART Act
- Pregnant women (prior to the birth of their children) are eligible for the following five preventive dental services in addition to the dental benefits listed for all eligible adults:
 - Periodic Oral Evaluation
 - Cleaning
 - Periodontal Scaling and Root Planing-4 or more teeth per quadrant
 - Periodontal Scaling and Root Planing-1-3 teeth per quadrant
 - Full Mouth Debridement

Four Prescription Policy



- HFS has reduced the number of prescriptions that can be filled in a thirty-day period, without prior authorization, to four. Information regarding this policy is posted on the web site at:
<http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx>
- Exceptions to the prescription policy will be allowed in certain situations, with prior approval. As a reminder, effective July 1, 2014 Senate Bill 741 eliminated the prior authorization requirement anti-psychotic drugs and for children with complex medical needs enrolled in a CCE solely to coordinate their care.
- A prior approval request for exception can be initiated electronically on the MEDI system. Please refer to the September 4, 2012 informational notice entitled Drug Prior Approval/Refill Too Soon Entry System), posted on the web site at
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120904b.aspx>
- Effective with the December 10, 2013 provider notice at
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131210a.aspx>, the Department will not require prior approval or four prescription policy overrides for anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder according to Department records

Submittal of Claims for Multi-Use Vials

- Please refer to the November 10, 2014 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141110a.aspx>
- When billing the Department for a multi-use vial, providers must bill only for the quantity of the drug actually dispensed
- Claims submitted for an entire vial, when a partial vial was used are subject to audit and/or recoupment of any payment made for the unused portion of the medication

Annual Medical Cards

- Please refer to the provider notice dated January 30, 2013 at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130130a.aspx>
- ***Providers should verify medical eligibility at each visit or risk non-payment***
- Providers may not charge participants to verify eligibility
- If the individual provides a Medical Card, Recipient Identification Number (RIN), or Social Security number and date of birth, providers may verify eligibility through one of the following resources:
 - MEDI Internet site at:
<http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx>
when using MEDI be sure to scroll down to view possible MCO enrollment
 - The REV system. A list of vendors is available at:
<http://www.illinois.gov/hfs/MedicalProviders/rev/Pages/default.aspx>
 - The Automated Voice Response System (AVRS) at 1-800-842-1461

Home Health Care Services Reminder of Face-To-Face Requirement

- Beginning with dates of service January 1, 2014, the Department requires that the initial certification of Home Health intermittent skilled nursing services and/or therapy services include documentation that a face-to-face encounter was conducted by the practitioner ordering the home health services
- Please refer to the December 11, 2013 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131211a.aspx> for further information and details regarding the face-to-face encounter

180 Day Time Limit for Claim Submittal

- Please refer to the August 9, 2016 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160809a.aspx>
- Claim submittals are subject to a filing deadline of 180 days from the date of service
- *Timely filing applies to both initial and re-submitted claims*
- Claims submitted greater than 180 days but less than 365 days from the date of service will reject G55/Submitted later than 180 days, but not more than one year, from date of service”
- Claims submitted greater than 365 days from the date of service will reject D05/”Submitted greater than one year from date of service”
- Medicare crossovers (Medicare payable claims) are subject to a filing deadline of two years from the date of service
- Please refer to the Non-Institutional Providers Resources webpage at: <http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx> for links to:
 - The Timely Filing Override Submittal Instructions, includes a list of exceptions to the timely filing deadline and instructions regarding how to request time override
 - The HFS 1624, Override Request form
 - Timely Filing Override Q & A



Co-Pays/Cost Sharing

- Co-pay amounts are *not* reflected on the medical cards but may be found on MEDI
- Please refer to the March 29, 2013 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130329a.aspx> and Chapter 100, Appendix 12 for the most up-to-date information about co-payment amounts and applicable eligibility categories
- The Q & A document referenced in the February 14, 2014 provider notice regarding participant liability and co-payments is now available at the Non-Institutional Providers webpage at:
<http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx>
- When billing the Department *providers should not report the co-payment* nor deduct it from their usual and customary charge, on the claim. The Department will automatically deduct the co-payment from the provider's reimbursement. This applies to direct billing to HFS – please check with the individual plans for guidance on billing for Medicaid managed care enrollees.

Co-Pays/Cost Sharing (cont'd)

Participants excluded from cost sharing include:

- Participants with Medicare as primary payer
- Pregnant women, including a 60-day postpartum period. *Either a primary diagnosis of pregnancy in the V22-V39 series or 640-677 series on the claim or current/updated EDD (estimated due date) on the MEDI system are required.*
- All Kids Assist (HFS-covered children under 19 years of age who are not All Kids Share or All Kids Premium)
- Residents of nursing homes, ICFs for the developmentally disabled, and supportive living facilities
- Hospice patients
- All non-institutionalized individuals whose care is subsidized by DCFS or Corrections

Co-Pays/Cost Sharing (cont'd)

Services exempt from cost sharing include:

- Well-child visits
- Immunizations
- Preventive services for children and adults
- Diagnostic services
- Family Planning medical services and contraceptive methods provided
- Services provided under the Breast and Cervical Cancer (BCC) program
- Community Mental Health Services

Co-pays/Cost Sharing and TPL

- Medicaid is nearly always the payer of last resort
- Participants with other insurance/third party liability and Medicaid secondary may be charged the Medicaid co-payment if accepted as a Medicaid patient, but may not be charged the insurance co-payment
- Example:
 - Adult patient, sick visit, has United Healthcare primary with a \$20 co-payment, and is enrolled in HFS Family Care Assist with a \$3.90 co-payment
 - Provider accepts patient as having Medicaid secondary
 - Provider cannot collect the \$20 UHC co-payment, but can collect the HFS \$3.90 co-payment, even if HFS pays \$0.00 because the TPL reimbursement exceeds the state maximum allowed amount

Cost Sharing for Medicare Advantage Plan (MAP) Members

- Please refer to the June 19, 2015 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150619b.aspx>
- For dates of service July 1, 2015 and after, providers may bill the Department for Medicare co-insurance and deductibles for individuals enrolled in a Medicare Advantage Plan and Medicaid
- HFS will consider cost-sharing when the participant is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits
- Providers must submit claims with the twenty-four (24) month timely filing limit for Medicare crossovers
- Non-Institutional providers are required to submit a paper HFS 3797, Medicare Crossover or 837P and institutional providers are required to submit a paper UB04 or 837I to the Department
- Expect new information regarding MAP & MMAI billing soon

Group Psychotherapy

- Effective with dates of service on or after July 1, 2012, HFS eliminated coverage of group psychotherapy for participants who are residents in a nursing facility, institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act. For details please refer to the provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120627b.aspx>
- Per the July 23, 2012 addendum to the June 27, 2012 provider notice, the procedure codes affected by this change are 90853 and 90849. The July 23, 2012 addendum may be viewed at: <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120723b.aspx>
- Please refer to the June 26, 2014 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140626c.aspx> for details regarding a policy reversal to allow mid-level staff to bill for group psychotherapy rendered in a FQHC or RHC.
- Group psychotherapy rendered by a physician is billable as a medical encounter
- Group psychotherapy rendered by mid-level staff is billable as a behavioral encounter

Therapy Services

- An *initial* therapy treatment (prior to referral to a licensed therapist) provided by a physician, PA or APN is billable as a medical encounter
- Ongoing therapy services are only reimbursable when rendered by an enrolled therapist
- Ongoing therapy services provided by an enrolled therapist are reimbursable FFS provided they were not included in the clinic's cost report submitted to the Department
- The therapy services handbook may be found at <http://www.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf>
- The therapy services fee schedule at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx>

Sexual Assault Emergency Treatment Program

- Effective with dates of service on or after July 1, 2012, HFS began reimbursing all services provided to survivors of a sexual assault through the Sexual Assault Emergency Treatment Program at the Department's standard reimbursement rates, including follow-up care
- For details and billing instructions please refer to the June 29, 2012 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120629b.aspx>
- Hospitals must register all non-Medicaid sexual assault patients in the MEDI Early Registration of Sexual Assault Survivor's System and issue follow-up Authorization for Payment Vouchers for direct payment to service providers - all providers should include a copy of this authorization with their claim

Services to Hospice-Enrolled Participants

- Effective with dates of service on or after July 1, 2012, some services are no longer covered for non-hospice providers serving patients enrolled in the Department's hospice program
- These restrictions do not apply to Medicare recipients or participants under age 21 years
- For details and a complete list of non-covered services please refer to the June 27, 2012 provider notice at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120627a.aspx>
- These restrictions do not affect services provided and billed by the hospice agency
- Exception: Physician and APN services will be reimbursed only if the service is not related to the terminal illness, identified on a claim by applying the GW modifier to the T1015 encounter code

Definition of an Encounter

An encounter is defined as a face-to-face visit with one of the following:

➤ **Medical encounter:**

- Physician
- Psychiatrist
- Physician Assistant
- Nurse Practitioner or Midwife

➤ **Dental encounter**, if the clinic is enrolled to provide dental services:

- Dentist

➤ **Behavioral Health encounter**, if the clinic is enrolled to provide behavioral health services:

- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselor
- Licensed Marriage and Family Therapist

Billable Place of Service for Encounters

- Office
- Patient's home - if the patient is homebound
- Long Term Care facility - if it is the patient's permanent place of residence
- School – if the clinic has a school-based or school-linked specialty

Encounter Clinic Billing

- Encounter Clinics may bill only one medical encounter per patient per day
- If enrolled for dental services, Encounter Clinics may bill for only one dental encounter per patient per day
- If enrolled for behavioral health services, Encounter Clinics may bill for only one behavioral health encounter per patient per day
- If several different encounter types occur on the same date of service each encounter should be submitted on a separate claim

Encounter Clinic Billing (cont'd)

- Claims must be submitted with the encounter CPT code (T1015 or S5190) listed in the first service section along with the clinics assigned encounter rate
- If T1015 or S5190 is billed in any other service section the claim may reject for “no covered service”
- The CPT codes for the services provided must then be listed in the remaining service sections. These codes are referred to as the *detail codes* and will be reimbursed at \$0.00.
- An exception to the above is when billing for Medicare recipients on the HFS 3797 – only T1015 needs to be billed. Detail codes are not required.

Encounter Clinic Billing (cont'd)

Detail codes billed should include all services provided so long as they are provided as part of a billable encounter, such as:

- Evaluation/Management services
- Laboratory (if CLIA) and/or x-ray services
- Immunizations administered
- Assessments/Screenings completed
- Procedures performed

Behavioral Health Encounter Codes

Licensed Clinical Social Worker

COS 58

Bill T1015 with AJ modifier plus detail code

Licensed Clinical Psychologist

COS 59

Bill T1015 with AH modifier plus detail code

Licensed Clinical Professional Counselor

COS 88

Bill T1015 with HO modifier plus detail code

Licensed Marriage and Family Therapist

COS 88

Bill T1015 with HO modifier plus detail code

**COS indicates Category of Service. The behavioral health COS for which a clinic is enrolled is determined by the specialty and subspecialties chosen in IMPACT and can be found on the provider information sheet.

EPSDT Codes

- Well-Child Visits/Preventive Medicine Services are billable according to the periodicity schedule in topic HK-203.1.1 of the Healthy Kids Handbook
 - 99381-99385 new patients
 - 99391-99395 established patients

- Developmental Screening
 - 96110

- Developmental Assessments
 - 96111

- Immunizations (Vaccine billing instructions are located in Chapter 200, Appendix A-9)
 - 90476-90749

EPSDT Codes (cont'd)

- Lead Screenings
 - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the specimen collection
 - if specimen is not being sent to IDPH and is being analyzed at the office bill 83655
- Hearing Screening
 - 92551
- Vision Screening
 - 99173
- Labs/X-rays
- Mental Health Risk Assessment
 - 99420

Additional information may be found in the Healthy Kids Handbook (HK-200) & Appendices at:

<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/HK200.aspx>

Adult Preventive Services

- Adult Preventive Visits
 - 99385-99387 new patients
 - 99395-99397 established patients
- Immunizations
 - billable when medically necessary and administered according to CDC guidelines so long as they are provided as part of a billable encounter
- Screening for cancer

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

- Please refer to the January 24, 2014 provider notice for details and billing instructions at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140124c.aspx>
- Providers are encouraged to follow recommended clinical guidelines for the evaluation & management of overweight and obesity according to the expert committee recommendations linked in the notice
- Primary care physicians and other providers are encouraged to routinely assess and document children's weight status at least one time per year for patients ages 2 through 20
- BMI assessment may be done during any sick or preventive visit. Claims for an episode where BMI is assessed must include the appropriate CPT and diagnosis codes as referenced in the notice
- Providers may bill for weight management visits for children with BMI >85th percentile as measured and documented according to the notice. Payable weight management visits may include a maximum of 3 visits within 6 months and may not be billed on the same day as a preventive medicine visit.

Prenatal/Perinatal Services

- Prenatal Services
 - 0500F (initial prenatal visit) – date of the last menstrual period (LMP) must be reported when billing the initial prenatal CPT
 - 0502F (subsequent prenatal visit) – routine urinalysis is not separately reimbursable
 - 0503F/59430 (postpartum visit)
- Perinatal Depression Risk Assessment
 - H1000 (screening during a prenatal visit)
 - 99420 with HD modifier (screening during a postpartum visit)
 - Screening during the infant's visit when the mother is not Medicaid eligible is considered a risk screening for the infant ; bill 99420 with HD modifier using the infant's RIN
- Additional information is available at:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn041130d.aspx>

Newborn Eligibility

- Any child born to a participant is automatically eligible for medical assistance for one (1) year as long as the mother remains eligible for assistance and the child lives with her
- The mother is not required to submit a formal application for the child to be added to her case
- Medical providers may request that a newborn be added to the Medical Assistance case by contacting the local DHS Family Community Resource Center. Local site locations can be found at: www.dhs.state.il.us

Newborn Care



- Newborn care includes the history and examination of the infant, daily hospital visits, initiation of diagnostic and treatment programs, preparation of hospital records including hospital discharge summary
- Charges for *normal* newborn care, when the child's name does not appear on the medical card, may be submitted as follows:
 - Patient Name – enter “Baby Girl” or “Baby Boy”
 - Date of Birth – enter the newborn's birth date
 - Recipient Identification Number – enter the mother's RIN
 - Date of Service – complete the service date box to show the date newborn care was provided
- Billing must be submitted with the child's name and participant number when:
 - The newborn develops complications (i.e. jaundice)
 - The newborn is transferred to NICU
 - A newborn male is circumcised
 - Services are provided after discharge

Long-Acting Reversible Contraceptives (LARCs) and Transcervical Sterilization Devices

- Effective with dates of service beginning July 1, 2012, IUDs and implantable contraceptives may be billed fee-for-service
- The provider who inserts the IUD or contraceptive must purchase the product and bill the Department for both the product and the insertion procedure
- These products are available for purchase through the 340B Drug Pricing Program for those who are 340B providers
- Please refer to the February 26, 2013 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130226a.aspx> for changes in billing and payment policy for IUDs and implantable contraceptives

Billing for Long-Acting Contraceptives and Transcervical Sterilization Devices

Billing guidelines:

- These charges should be billed at the actual acquisition cost and on a separate claim from the encounter claim for the insertion procedure
- If purchased under the 340B drug pricing program, charges should be billed at the actual acquisition cost with a UD modifier
- Reimbursement will be made at the actual acquisition cost or the state max rate on the Practitioner Fee Schedule, whichever is less
- Reimbursement is separate from any encounter payment the clinic may receive for the insertion procedure
- If the contraceptive device is not billed separately from the encounter or other services, the claim will reject G70

Procedure Code S5190

- Wellness Assessment, performed by non-physician; limited to FQHCs, RHCs, and ERCs
- Used instead of T1015 and cannot be billed on the same claim as T1015
- For reporting purposes only; not payable
- Must be billed with at least one additional covered HCPCS code
- Example: vaccine given by RN without physician visit
- For more information please refer to the April 23, 2012 provider notice at <http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120423a.aspx>

Provider Fee Schedules

- Fee schedules are posted at:
<http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx>
- The Practitioner Fee Schedule may be referenced for a list of covered services billable as detail codes on an encounter claim
- The Practitioner Fee Schedule provides information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization. The fee schedule should be used in conjunction with the fee schedule key, modifier listing, lab panel table, and assistant surgeon rates as applicable.
- Please refer to the applicable fee schedule for a list of covered services and rates for fee-for-service claims

HIPAA 5010

- The Chapter 300 Companion Guide for 5010 may be viewed at: [http://www.hfs.illinois.gov/handbooks/chapter 300.html](http://www.hfs.illinois.gov/handbooks/chapter%20300.html)
- 5010 submissions will receive a 999 Functional Acknowledgement
- If a 999 is not received please contact 217-524-3814 for technical assistance, as this may indicate the claim/file was not successfully received
- **Please note: A second 999 Functional Acknowledgment is possible as additional audit checks are completed. A second 999 always indicates rejection of the claim/file. Please be aware of this possibility and verify that HFS has accepted all submitted files.**

837P HIPAA 5010

When billing:

- Encounter claims - the first service section procedure code must be the applicable encounter code (either T1015 or S5190), with detail codes
- FFS claims for IUDs, implantable contraceptives, and transcervical sterilization devices - do not bill the encounter code or any other detail code(s). The only service line must be the procedure code.

Billing Format

Billing Loop 2010AA – Segment 85

- enter the Encounter Clinic's NPI and the clinic's taxonomy
- the NPI must be linked to the Encounter Clinic's HFS provider number *and* the HFS 16 digit payee number

Rendering Provider Loop 2310B – Segment 82

- enter the rendering provider's name and individual NPI
- the rendering provider will be passed through but not utilized in processing the claim

837P HIPAA 5010 (cont'd)

When billing Fee-For-Service claims *other than* IUDs, implantable contraceptives and transcervical sterilization devices:

Billing Format

Billing Loop 2010AA – Segment 85

- enter the NPI linked to the clinic
- the NPI must crosswalk to a payee on the rendering provider's file

Rendering Loop 2310B – Segment 82

- enter the rendering provider's name, individual NPI, and taxonomy

Service Line

- Bill the applicable CPT/HCPCS code
- an encounter code (T1015, S5190) is not billable

Third Party Liability

- Medicaid is nearly always the payer of last resort. All known TPL must be billed before claims may be submitted to HFS. Exceptions include services to women with a diagnosis of pregnancy and preventive services for children.
 - Antepartum care services are not required to be billed to a participant's private insurance carrier prior to billing the Department, however practitioners must bill a participant's private insurance carrier prior to billing the Department for deliveries
 - Please refer to topic A-223.41 **Prenatal Care** and A-223.44 **Delivery** of Chapter 200 of the Providers Handbook at:
<http://www.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf>
 - Participant-specific TPL appears on the MEDI eligibility detail screen
 - Medicare crossover claims must contain the amount paid by Medicare for each service
 - When a participant is identified on the HFS system as having TPL, even if the participant or TPL source states the TPL is not in effect, the claim must contain complete TPL information, including:
 - TPL resource code - TPL Resource Code Directory appears in Chapter 100, Appendix 9
 - TPL status codes – TPL status codes appear in Appendix 1 of most Chapter 200 Provider Handbooks
 - Payment amounts
 - TPL date - instructions appear in Appendix 1 of most Chapter 200 Provider Handbooks
- **For discrepancies between TPL reported by participants and information on MEDI, please contact the TPL unit at 217-524-2490

Medical Electronic Data Interchange (MEDI)

➤ MEDI is available for:

- Verifying participant eligibility
- Submitting claims
- Submitting replacement claims (bill type '7')
- Submitting voids (bill type '8')
- Downloading the 835 Electronic Remittance Advice
- Checking claim status

****PLEASE NOTE: HFS BILLING CONSULTANTS DO NOT CHECK CLAIM STATUS****

➤ Login and access requires a State of Illinois Digital Identity

➤ For new users:

- Obtaining a State of Illinois Digital ID is a one-time process
- Requires entry of Illinois-based information from Driver's License/State Identification Card
- Registration must match the provider's information sheet

➤ There are two types of USER registration in the MEDI System:

- Administrator (required - limit of 2)
- Employees (no limit)



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MEDI (cont'd)

- ANSI 835 (Electronic Remittance Advice) is in Production
- The 835 is available to the designated payee
- HFS error codes are not included on the 835. Codes provided on the 835 are national reason and remark codes which can be found at: <http://www.wpc-edi.com/reference>.
- Providers should refer to the subsequent paper remittance advice for additional information regarding claim rejections

MEDI (cont'd)

- Once the Illinois Digital Identity registration is complete, login to:
<http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx>
- For technical assistance with the following please contact 217-524-3814:
 - Authentication error (non-password)
 - Upload batch
 - 835 (ERA) and 999 (FA) assistance
- For technical assistance with the following please contact 1-800-366-8768, option 1, option 2:
 - registration
 - digital certificate/password reset
 - administrator/biller authorization

Voids & Replacement Claims

➤ Voids

- May be completed on paper by using the HFS 2292 NIPs Adjustment Form. The Department will no longer stock a paper version for ordering from the warehouse. Providers must use the PDF-fillable format available at the 'Medical Forms Alphabetical Listing' or 'Medical Forms Numeric Listing' link on the Medical Forms page at: <http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx>.
- The instructions for completion of the HFS 2292 may be found in Appendix 6 of the Chapter 100 handbook at: <http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx>
- May be completed electronically by using bill type '8' to void a single service line or entire claim

➤ Replacement Claims

- completed electronically by using bill type '7' to void a single service line or entire claim

➤ The instructions for electronic voids and replacement claims may be found in the Chapter 300 Companion Guide at:

<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>

- ## ➤ Please Note: voids and replacement claims require the 17-digit DCN from the original, paid claim. Using the 12-digit DCN from the paper remit:
- Add '201' to the beginning of that 12-digit number
 - Add **either** the 2-digit section number to void or replace a single service line, **or** '00' to void or replace an entire claim, to the end of that 12-digit number

COMMON BILLING ERRORS

- C03 – illogical quantity
- C17 – place of service illogical
- D01 – duplicate claim – previously paid this provider, this recipient, this DOS, this code
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 / R39 – client enrolled in managed care, provider must bill the plan
- R36 – client has Medicare – bill Medicare first
- X05 – Hospital visit disallowed
- X06 – surgical package previously paid
- H50 – payee not valid for provider
- M93 – missing payee/multiple payees
- H55 – rendering NPI missing/invalid
- G55 – submitted later than 180 days, but not more than one year, from date of service
- C97 – No payable service on claim (encounter claims with no payable detail code)
- T21 -- Client has Third Party Liability

Chapter 100 Handbook, Appendix 5 details HFS remittance advice error codes at:
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx>

Contact Numbers for Billing Questions or Prior Approval

Main Number : 877-782-5565



PLEASE NOTE.....

- HFS Medical Programs has recently implemented a new phone system and menu options have changed. Please be aware that menu options will change again in the near future.
- Claim status is *not* available by phone. Claim status is available using MEDI, the 835 ERA, and the paper remittance advice.



- HFS Home Page <http://www.illinois.gov/hfs/Pages/default.aspx>
- Laws and Rules: <http://www.illinois.gov/hfs/info/legal/Pages/default.aspx>
- Handbooks, including appendices:
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx>
 - Chapter 100 – General Policy and Procedures
 - Chapter 200 – Provider Handbooks by provider type
 - Chapter 300 – Handbook for Electronic Processing
- Provider Releases and E-Mail Notification for Releases:
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx>

