



# Handbook for Providers of Audiology Services

**Illinois Department of Healthcare and Family Services**

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**Revision History**

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## Foreword

The Department of Healthcare and Family Services (HFS) or “Department” is the agency that administers Illinois’ Medical Assistance (Medicaid) Program, as well as other public healthcare programs. This handbook, along with recent [provider notices](#) and the [Handbook for Providers of Medical Services, General Policy and Procedures](#), will act as an effective guide to participation in the [Department’s Medical Programs](#). 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 and are posted on the [Provider Handbooks](#) webpage. The Department encourages providers to utilize the [Provider Handbook Supplement](#) for guidance in claim submittal.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive [e-mail notification](#) when additional information has been posted by the Department.

Charges for services provided to participants enrolled in a [HealthChoice Illinois](#) managed care organization (MCO) must be billed to the MCO. Providers should always verify eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant’s coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The [Recipient Eligibility Verification \(REV\)](#) System, the Automated Voice Response System (AVRS) at 800-842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

Providers submitting X12 electronic transactions must refer to the [Handbook for Electronic Processing](#). This handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Department. Inquiries regarding coverage of a service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 877-782-5565.

## 201 Provider Enrollment

The web-based provider enrollment system is known as Illinois Medicaid Program Advanced Cloud Technology ([IMPACT](#)). When enrolling in IMPACT, a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required. The [table of IMPACT Provider Types, Specialties and Subspecialties](#) is a reference guide that provides important information for providers enrolling via IMPACT.

### 201.1 Enrollment Requirements

An audiologist who is licensed by the [Illinois Department of Professional Regulation](#) or their state of practice is eligible to be considered for enrollment and participation in the Department’s Medical Programs.

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A certified hearing instrument dispenser who is not an audiologist but is registered by the [Illinois Department of Public Health](#) to dispense hearing aids is eligible to be considered for enrollment to participate in the [Department's Medical Programs](#). If enrollment is granted, the non-audiologist certified hearing instrument dispenser is enrolled as a medical equipment provider who may provide hearing aids, and hearing aid-related services such as accessories, supplies and repairs.

An audiologist or certified hearing instrument dispenser who provides hearing aids and hearing aid related services such as accessories, supplies and repairs must also comply with requirements set forth in the [Handbook for Providers of Medical Equipment and Supplies](#).

### **201.2 Enrollment Approval**

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data as it appears on the Department's files. The provider is to review this information for accuracy immediately upon receipt. If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing billing statements to ensure that all identifying information required is an exact match to that in the Department file.

Enrollment of a provider is subject to a provisional period and shall be conditional for one-year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or disenroll the provider from the Medical Assistance Program without cause.

### **201.3 Enrollment Denial**

When enrollment is denied, the provider will receive written notification of the reason for denial. Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of enrollment are set out in [89 Ill. Adm. Code 140.14](#). Department rules concerning administrative hearing process are set out in [89 Ill. Adm. Code 104 Subpart C](#).

### **201.4 Provider File Maintenance**

The information in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated. The provider should ensure that all information in the IMPACT system is accurate and up to date at all times. Provider Enrollment Services (PES) is the section within the Department of Healthcare and Family Services that is responsible for reviewing and approving any modifications to provider enrollment records.

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## 201.5 Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected by submitting a modification in [Illinois Medicaid Program Advanced Cloud Technology \(IMPACT\)](#).

Provider change information must be updated via the on-line application available on the IMPACT Provider Enrollment web page. The on-line change function is available to notify the Department of updates or changes to enrollment information for the following categories:

- National Provider Identifier (NPI)
- Provider name
- Provider demographic (address, phone, email)
- Payee demographic (address, phone, email)
- Add a Pay To (payee)
- Close a Pay To (payee)
- Close enrollment
- License
- Clinical Laboratory Improvements Amendments (CLIA)

Failure of a provider to properly update the [IMPACT](#) provider enrollment system with corrections or changes may cause an interruption in participation and payments.

## 201.6 Department Responsibility

When a provider submits a modification in IMPACT, the Department will review the request and either reject or approve the modification. The Department will generate an updated Provider Information Sheet reflecting the modification and the effective date of the modification, if appropriate. The updated sheet will be sent to the provider's office address and to all billing providers associated to the provider in IMPACT.

## 202 Provider Reimbursement

### 202.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the public for the same service or item. Providers may only bill the [Department](#) after the service has been provided. To be eligible for reimbursement, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service, or within 24 months from the date of service when Medicare or its fiscal intermediary must first adjudicate the claim, unless one of the exceptions to the timely filing rule applies. Refer to the [Timely Filing Override Submittal Instructions](#) for a list of exceptions to the 180-day rule and billing instructions for each.

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Covered services must be billed to the Department using the [Current Procedural Technology \(CPT\)](#) codes or alphanumeric HCPCS codes. An audiologist may only charge for services he or she personally provides. A certified hearing instrument dispenser may only charge for the equipment dispensed. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

## 202.2 Claim Preparation and Submittal

For information on policy and procedures regarding claim submittal, including billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to [Handbook for Providers of Medical Services General Policy and Procedures](#). For technical guidelines for claim preparation and submittal refer to the [Handbook Supplement](#).

### 202.2.1 Paper Claim Submittal

The Department will not accept paper claim forms hand-delivered to HFS office buildings by providers or their billing entities. HFS will return hand-delivered claims to the provider identified on the claim form. All services for which charges are made must be coded on the appropriate claim form.

For general information on billing Medicare covered services provided and submittal of claims for participants eligible for Medicare Part B, refer to the [Handbook for Providers of Medical Services General Policy and Procedures](#).

Form [HFS 3797 \(pdf\)](#), Medicare Crossover Form, is to be used to submit Medicare allowable crossover charges. Detailed instructions for completion are included in the [Handbook Supplement](#).

Form [HFS 1443 \(pdf\)](#), Provider Invoice, is to be used to submit charges for audiological services provided to a Department's Medical Programs participant. Detailed instructions for completion are included in the [Handbook Supplement](#).

Form [HFS 2210 \(pdf\)](#), Medical Equipment /Supplies Invoice, is to be used to submit charges to the Department for a hearing aid, hearing aid accessories, supplies, equipment, hearing aid repairs and the dispensing fee. Detailed instructions for completion are included in the [Handbook Supplement](#).

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and allows attachments to be scanned. The Department offers a claim scannability/imaging evaluation. Turnaround on a claim scannability/imaging evaluation is approximately seven to ten 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:

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Healthcare and Family Services  
 201 South Grand Avenue East 2nd Fl - Data Preparation Unit  
 Springfield, Illinois 62763-0001  
 Attention: Vendor/Scanner Liaison

Routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, HFS 2244. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use HFS 2248, Special Approval Envelope. A non-routine claim is any claim to which any other document is attached. Non-routine claims may not be electronically submitted. Medicare crossover claims for emergent trips, cannot be billed electronically.

If envelopes are unavailable, the claims can be mailed to:

Healthcare and Family Services  
 Post Office Box 19126  
 Springfield, IL 62794-9126

HFS 3797 (Medicare Crossover Invoice) with and without attachments:  
 Healthcare and Family Services  
 Post Office Box 19109  
 Springfield, IL 62794-9109

Providers must use the Department's original claim forms. Carbon copies, photocopies, facsimiles, or downloaded forms are not acceptable. Forms and envelopes should be requested on the Department's website.

### **202.2.2 Electronic Claim Submittal**

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in the [Handbook for Providers of Medical Services General Policy and Procedures](#) and [Companion Guide](#).

Providers billing electronically should take special note that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the remittance advice (voucher). Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims.

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### 202.3 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

All claims processed by the Department are assigned a 12-digit Document Control Number (DCN). The DCN format is YDDDLLSSSSSS:

Y - Last digit of year claim was received  
 DDD - [Julian date](#) claim was received  
 LL - Document Control Line Number  
 SSSSSS - Sequential Number

Adjudicated claims are identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the provider's payee address on file with the Department. Refer to the [All Providers Handbook Supplement](#) for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

### 202.4 Fee Schedule

The [fee schedule](#) of allowable procedure codes and special billing information is available on the Department's website. For DME providers and audiologists who provide hearing aids and hearing aid supplies, there is a listing by HCPCS code. The DME [fee schedule](#) lists the maximum rates, quantity limitation, whether the item is covered for residents of Long Term Care facilities and prior approval requirements for each item. For an audiologist's professional services there is an Audiology [fee schedule](#) which lists CPT codes used for diagnostic testing.

Providers will be advised of major changes via an electronic notice. Providers should sign up to receive [electronic notification](#) of new releases on the Department's website. Please mark "All Medical Assistance Providers" as well as each specific provider type for which notification is requested.

### 203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with [89 Ill. Adm. Code 140.3](#). The services covered in the Medical Assistance Program are limited and include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

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Audiologists who bill the Department for payment must have in the patient file a referral from a practitioner, i.e., an Otologist, Otolaryngologist Primary Care Physician, Advanced Practice Nurse or Physician Assistant, as applicable.

Questions about coverage of a service should be directed to the Department prior to provision of the service. Providers may call the Bureau of Professional and Ancillary Services at 877-782-5565.

### 203.1 Audiologist

Audiologists are authorized to provide basic and advanced hearing tests, evaluation of auditory rehabilitation status related to cochlear implantation, vestibular tests, hearing aid related testing and evaluation, hearing aid counseling, hearing aid fitting, and the sale of the hearing aid itself. Coverage also includes provision of hearing aid accessories, replacement of parts, and repairs.

There are procedure codes for audiologists only which pertain to follow-up services after a cochlear implant. These codes are not to be used under any other circumstance and can be found on the audiology [fee schedule](#).

An audiologist who sells and dispenses hearing aids in addition to providing professional audiology services is expected by the Department to adhere to statutes guaranteeing the patient's freedom of choice of providers. The audiologist must instruct the patient that they may obtain a hearing aid from any enrolled provider who can supply the appropriate aid.

### 203.2 Non-Audiologist Businesses

[DME](#) providers may provide hearing aids and hearing aid-related services and items but not professional audiology services for which an audiologist's academic credentials and licensing are required.

Certified hearing instrument dispensers are eligible to provide hearing aid fitting, sale of the hearing aid itself, hearing aid accessories, replacement parts and repairs.

### 203.3 Hearing Aids

Providers must charge the **actual acquisition cost** of the hearing aid. The actual acquisition cost is the actual payment by the supplier for the hearing aid, considering any discounts, rebates or bonuses. The full amount of the discount must be subtracted when calculating the actual acquisition cost. The amount of any rebates or bonuses must be prorated to all purchases on which the rebate or bonus was earned. The prorated share must be subtracted when calculating the acquisition cost of the hearing aid.

The date of service to be submitted when billing for a hearing aid is the date the hearing aid is dispensed, not the fabrication date. The participant must be eligible on the dispensing date for providers to receive reimbursement from the Department.

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A dispensing fee may be billed at the time the hearing aid is dispensed to the patient. The dispensing fee includes, but is not limited to payment for fitting, follow-up visits, shipping fees and retail mark-up for the hearing aid.

**Exception:** HFS covers hearing aid batteries. Allowable quantities are listed on the [fee schedule](#). Batteries are not covered for clients who reside in a Long-Term Care (LTC) facility. It is the responsibility of the LTC facility to provide its residents with batteries as the cost of the hearing aid batteries are included in the payment made by the Department to the LTC facility.

Provision of a hearing aid, whether by an audiologist or a DME provider, must include a minimum one-year warranty at no expense to the Department. Repair costs covered by the warranty are not to be submitted to the Department for payment.

### 203.3.1 Hearing Aid Criteria

To be eligible for reimbursement from the Department for hearing aids, the following criteria must be met:

When testing is performed in an acoustically treated sound suite:

The hearing loss must be 20 decibels (dB) or greater at any two of the following frequencies: 500, 1000, 2000, 4000, 8000 Hertz (Hz),

or

The hearing loss must be 25 dB or greater at any one of 500, 1000, 2000 Hz.

When testing is performed at a site other than an acoustically treated sound suite:

The hearing loss must be 30 dB or greater at any two of the following frequencies: 500, 1000, 2000, 4000, 8000 Hz,

or

The hearing loss must be 35 dB or greater at any one of 500, 1000, 2000 Hz.

### 203.4 Early Intervention Services

[Early Intervention \(EI\)](#) services are covered for children up to the age of three years, who are eligible for Part C services under the Individuals with Disabilities Education Act and when those services are included in the child's Individualized Family Service Plan. Procedure codes for EI services must be billed to the EI Central Billing Office (CBO) for payment. To receive payment from the CBO, a provider must apply for and obtain an Early Intervention Credential, enroll as a provider with the CBO and have prior authorization to provide services.

- For credential and enrollment information, contact Provider Connections at 800-701-0995.

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- For questions about the service authorization and billing processes, contact the Early Intervention CBO Cornerstone Call Center at 800-634-8540.

## 204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to [89 Ill. Adm. Code 140.6](#) for a general list of non-covered services.

In addition, the following services are excluded from coverage in the Department's Medical Programs and payment cannot be made for the provision of these services:

- Routine periodic exams in the absence of an identified problem.
- Examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from non-medical funds. Audiologists are to follow specific billing instructions given when such a request is made.)
- Expenses associated with postage and handling for any items.
- Travel expenses to provide testing.
- Batteries in a long-term care setting.

No separate additional charge is to be made for freight, postage, delivery, instruction, fitting, adjustments or measurement, since these services are considered to be inclusive in a provider's dispensing fee charge. These additional charges cannot be billed to the patient.

## 205 Record Requirements

Refer to the [General Policy and Procedures](#) for information regarding the maintenance of records and the retention of records. In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record must be kept with chronological entries by the individual provider rendering services.

The record maintained by the audiologist must include the essential details of the patient's condition and of each service or item provided. Any services provided to a patient by the audiologist outside the audiologist's office are to be documented in the medical record maintained in the audiologist's office. All entries must include the date and must be legible. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted.

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For patients who are in a nursing facility, the primary medical record indicating the patient's condition, treatment, and services ordered and provided during the period of institutionalization may be maintained as a part of the of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, must be maintained by the audiologist as an office record to show continuity of care.

In addition to record requirements discussed in the Handbook for Providers of Medical Services, [General Policy and Procedures](#), an audiologist's records are to include the following information:

- A copy of the referral from the Practitioner (otologist, otolaryngologist, primary care physician, Advanced Practice Nurse or Physician Assistant).
- A copy of the manufacturer's invoice with the patient's name and hearing aid serial number.
- Hearing aid evaluation results.
- Diagnosis.
- Audiogram.
- Medical history relevant to audiology services.
- Dates services or items were provided.
- A copy of the manufacturer's invoice for an ear mold, if applicable.

## 206 Prior Approval Process

Prior to the provision of certain services, approval must be obtained from the Department. If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

### 206.1 Prior Approval Requests

Prior approval requests must contain enough information for Department staff to decide on medical necessity, appropriateness and anticipated patient benefits of the service.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

The following items or services may be provided only with prior approval by the Department:

- Binaural and/or monaural hearing aids and dispensing fees, if replacement is within three years of the initial or previous purchase.
- Quantity limits are exceeded.

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- Supplies/Accessories not elsewhere classified.

A prior approval request to provide hearing aids must be accompanied by the following:

- A copy of a Practitioner's order, signed by the practitioner and dated within the past twelve months, to allow the hearing aids to be fitted.
- The audiogram with the written recommendation.
- Documentation that reflects the actual acquisition cost of the hearing aid(s) or supplier's catalog price confirming acquisition costs.

Prior approval requests may be submitted to the Department by mail or fax.

**By Mail:**

Prior approval, when required must be requested by the provider using Form [HFS 1409 \(pdf\)](#), Prior Approval Request. Requests may be mailed to the Department in the Form HFS 2294, Prior Approval Request Envelope.

The completed form may be mailed to:

[Healthcare and Family Services](#)  
Bureau of Comprehensive Health Services  
Post Office Box 19124  
Springfield, IL 62794-9124

**By Fax:**

Prior approval may be requested by fax. Complete Form [HFS 1409 \(pdf\)](#), following the procedures described above for mailed request. The completed form, the practitioner order and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will be legible upon receipt. Colored documents do not fax clearly. The Department recommends that such documents be photocopied and that the copy be faxed.

The fax number for **initial and renewal prior approval requests** is 217-524-0099.

The fax number for **additional information and change requests** of an existing prior approval is 217-558-4359. The fax lines are available Monday through Friday, 8:30 AM to 5:00 PM, except holidays. The department is not responsible for any documentation sent to the incorrect fax line and will not process documentation that is sent to the incorrect fax line.

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## 206.2 Approval of Service

If the service requested is approved, the provider and the patient will be mailed a computer-generated letter, Form HFS 3076, Prior Approval Notification, listing the approved services. Upon receipt of the Prior Approval Notification and delivery of the items, the items may be billed.

Any changes/corrections needed to the prior approval notification HFS 3076, must be submitted as a review via mail or fax with supporting documentation to the prior approval unit. The prior approval fax line to receive reviews is 217-558-4359.

## 206.3 Denial of Service

If the service requested is denied, a computer-generated Form HFS 3076, citing the denial reason, will be sent to the patient and the provider. The provider cannot file an appeal of the denial. If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

## 206.4 Timelines

The Department is obligated to decide on hearing aid prior approval requests within thirty (30) days of receipt of a properly completed request, with exceptions as described in [Topic 206.5](#). If a decision has not been made within the thirty (30) day period, the service is automatically approved. If a service has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the supplying provider or the practitioner who ordered the service. If additional information is requested within fourteen (14) days of receipt of the prior approval request, the thirty (30) day period stops. When the required information is received, a new thirty (30) day period begins. An HFS 3701 will be generated when additional information is required.

The provider can request status of a prior approval after thirty (30) days from the Department's receipt date. This can be done by calling the prior approval unit at 877-782-5565, Option 1, 3, and 2.

## 206.5 Post Approvals

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Medical Assistance Program or for All Kids was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than

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ninety (90) days following the Department's Notice of Decision approving the patient's application.

- There was a reasonable expectation that other third-party resources would cover the item and those third parties denied payment after the item was supplied. To be considered under this exception, documentation that the provider billed a third-party payor within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than ninety (90) days from the date of final adjudication by the third party.
- The patient did not inform the provider of his or her eligibility for Medical Assistance or All Kids. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval must be met and post approval requests must be received by the Department no later than ninety (90) days from the date services or items are provided or within the time frames identified above.