



Handbook for Ambulatory Surgical Treatment Centers

Chapter G-200 Policy and Procedures For Ambulatory Surgical Treatment Centers

Illinois Department of Healthcare and Family Services

Issued December 2014

Chapter G-200

ASTC Services

Table of Contents

Foreword

Definitions

G-200 Basic Provisions

G-201 Provider Participation

- 201.1 Participation Requirements
- 201.2 Participation Approval
- 201.3 Participation Denial
- 201.4 Provider File Maintenance

G-202 Record Requirements and Audits

G-230 Covered Services

- 230.1 Facility Services
- 230.2 Non-Facility Services

G-240 Non-Covered Services

G-250 ASTC Reimbursement System

- 250.1 Reimbursement for Non-Surgical Procedures and Non-Facility Services
- 250.2 ASTC Reimbursement for Patients with Medicare Part B Coverage
 - 250.2.1 Claims Containing an APL Procedure
 - 250.2.2 Claims with No APL Procedure

G-254 Specialized Requirements for Certain Services

- 254.1 Hysterectomy
- 254.2 Sterilization Procedures Other Than Hysterectomy
- 254.3 Abortion Services

G-260 Payment Process

- 260.1 Charges
- 260.2 Claim Preparation and Submittal
 - 260.2.1 Split Bills (MANG-Spenddown)
- 260.3 Payment
- 260.4 Fee Schedule
- 260.5 Post Billing of Ancillary Charges

- 260.6 Payment Adjustments
 - 260.6.1 Void/Rebill Mechanism
- 260.7 Overpayments
- 260.8 Electronic Claim Submittal

G-270 Ambulatory Services

- 270.1 Ambulatory Procedures Listing (APL)
 - 270.1.1 Observation Requirements
- 270.2 Expensive Drugs and Devices

G-276 Reporting of National Drug Codes (NDCs)

Appendices

- G-1 Explanation of Information on Provider Information Sheet
- G-1a Facsimile of Provider Information Sheet

- G-2 UB-04 ASTC Outpatient Required Fields
- G-2a Mailing Instructions for the UB-04
- G-2b Supplemental Billing Instructions with Billing Scenarios
 - #1 – Outpatient Same Day Surgery with Spenddown
 - #2 – Late Ancillary Charges
 - #3 – Outpatient Claim with Third Party Liability (TPL)

- G-3 Non-Covered Revenue Codes

- G-4 Pricing Calculator for EAPG Reimbursement

- G-5 Internet Quick Reference Guide

Foreword

Purpose

This handbook has been prepared for the information and guidance of Ambulatory Surgical Treatment Centers (ASTCs) that provide items or services to participants in the department's Medical Programs. It also provides information on the department's requirements for provider participation and enrollment.

The [Handbook for Ambulatory Surgical Treatment Centers](#) can be viewed on the department's website.

This handbook provides information regarding specific policies and procedures relating to ASTC services. It is important that both the provider of service 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 in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the department's Medical Programs. The updates will be posted to the department's website on the [Provider Releases and Bulletins](#) page.

Providers will be held responsible for compliance with all policy and procedures contained herein. Providers wishing to receive [e-mail notification](#), when new provider information has been posted by the department, may register on the website.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Hospital and Provider Services at 1-877-782-5565.

Definitions

- [Ambulatory Procedures Listing \(APL\)](#) - A listing of procedures that have been determined by the department to be either unique to or most appropriately provided in the hospital outpatient or ambulatory surgical treatment center setting. Procedures provided in an outpatient setting must be included on the APL to be paid at the all-inclusive EAPG reimbursement (see below). If the procedure is not included, the service must be billed as fee-for-service.
- **Department of Healthcare and Family Services (HFS) or “department”** - 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.
- **Document Control Number (DCN)** – As identified on the HFS 194-M-2 paper Remittance advice, a twelve-digit number assigned by the department to identify each claim that is submitted by a provider. The 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
- **Enhanced Ambulatory Patient Groups Prospective Payment System (EAPG PPS)** - 3M Health Information Systems’ outpatient all-inclusive reimbursement for all services provided by the ASTC, without regard to the amount charged.
- **Fee-for-Service (FFS)** - A payment methodology for certain services provided in the ASTC outpatient setting for which the provider must conform to the policies and billing procedures for other non-institutional providers of services. Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-institutional setting.
- **HCPCS** – Healthcare Common Procedure Coding System
- **Institutional Claim Format** – Claims prepared in the 837I or Direct Data Entry (DDE) electronic formats or UB-04 paper claim format.
- **National Provider Identifier (NPI)** - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers, payees, and health plans. For healthcare providers and payees, this identifier is referred to as the National Provider Identifier (NPI).

- **Procedure Code** – For outpatient claims, the appropriate code from the American Medical Association Current Procedural Terminology (CPT) or appropriate Healthcare Common Procedure Coding System (HCPCS) code.
- **Provider Participation Unit (PPU)** – The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.
- **Recipient Identification Number (RIN)** – The nine-digit identification number unique to the individual receiving coverage under one of the department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.
- **Remittance Advice** – A document issued by the department which reports the status of claims (invoices) and adjustments processed. May also be referred to as a voucher.

Chapter G-200

ASTC Services

G-200 Basic Provisions

For consideration for payment by the department for ASTC services, an ASTC enrolled for participation in the department's Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the [Chapter 100](#), Handbook for Providers of Medical Services, General Policy and Procedures that can be found on the department's website and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the department's paper forms and apply to patients enrolled in traditional fee-for-service, Accountable Care Entities (ACEs), and Care Coordination Entities (CCEs) and **do not apply to patients** enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Further information can be found at the [HFS Care Coordination website](#).

ASTCs billing the outpatient services described in this handbook use the UB-04 claim form for billing paper claims. Providers wishing to submit X12 electronic transactions must refer to [Chapter 300](#), Handbook for Electronic Processing, found on the department's website.

Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

G-201 Provider Participation

G-201.1 Participation Requirements

An Ambulatory Surgical Treatment Center (ASTC) is defined as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

ASTCs do not include:

- Hospitals
- Nursing homes
- Dental or oral surgical centers
- State or federally managed facilities.

An ASTC holding the following qualifications is eligible to be considered for enrollment to participate in the department's Medical Programs:

- A valid license issued by the Illinois Department of Public Health (IDPH) under 77 Illinois Administrative Code Part 205 (or in the case of an out-of-state ASTC, the ASTC must be licensed by their state agency or accredited by a national accrediting body).
- Certification by the Social Security Administration for participation in the Medicare Program (Title XVIII).

An ASTC must comply with the participation requirements stated in Chapter 100.

Additionally, as part of IDPH licensure and department enrollment, the ASTC must:

- Maintain a contractual relationship, including a transfer and referral plan with a hospital that is within 15 minutes of the ASTC. The transfer and referral plan must include procedures for effecting transfer of the patient from the ASTC to the hospital. The transfer and referral plan must be maintained at the ASTC and provided to the department upon request. Additionally, the ASTC must have on file an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the ASTC capabilities.
- Ensure that a physician licensed to practice medicine in all its branches be present at the ASTC during the operative and post-operative period for all patients.

ASTCs may apply for enrollment with the department as Provider Type 46 – ASTC, as defined in 89 Illinois Administrative Code Part 146, to provide surgical services under Category of Service 24, General Outpatient Services.

The department also automatically enrolls ASTCs with Category of Service 01 - Physicians Services, to allow fee-for-service billing of radiology and laboratory services provided on dates other than the date of surgery.

To participate, an ASTC is required to enroll and file a provider agreement with the department.

Procedure: The provider must complete and submit:

- Form HFS 2243 (Provider Enrollment/Application)
- Form HFS 1413 (Agreement for Participation)
- Form HFS 1513 (Enrollment Disclosure Statement)
- W9 (Request for Taxpayer Identification Number), if the Federal Employer Identification Number has not been certified by the Illinois Comptroller
- IRS letter validating the facility's name and the Federal Employer Identification Number, if the Federal Employer Identification Number has not been certified by the Illinois Comptroller.

The following documentation must also be provided with the application:

- If located in Illinois, a copy of the facility medical license
- If located out-of-state, a copy of the facility's medical license with expiration date or a copy of The Joint Commission certification with expiration date
- A copy of the Clinical Laboratory Improvement Amendments (CLIA) certificate
- A copy of the facility's Medicare certification letter

These [enrollment forms](#) may be obtained from the department's website. Providers may also request the enrollment forms by [email](#).

Providers may also call the Provider Participation Unit at 217-782-0538 or mail a request to:

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

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms.

The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date on the HFS 1413 (Agreement for Participation) and this date is approved by the department. The effective date of enrollment, however, will be no more than 180 days prior to the receipt of the application.

Participation approval is not transferable. Refer to Topic G-201.2.

G-201.2 Participation Approval

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix G-1. If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the department files. If any of the information is incorrect, refer to Topic G-201.4.

When there is a change in ownership greater than 50%, a change in the facility name, or a change in the Federal Employer's Identification Number, the facility must complete a new application for participation.

In instances in which more than one ASTC is enrolled to provide services under the same Federal Employment Identification Number (FEIN), separate enrollment is required. A Provider Information Sheet will be prepared for each location showing the unique HFS provider number assigned.

G-201.3 Participation Denial

When participation 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 participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

G-201.4 Provider File Maintenance

The information carried 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.

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 are to be corrected and the department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, and sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

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

Failure of a provider to properly notify the department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, the department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

G-202 Record Requirements and Audits

The department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100 for record requirements applicable to all providers.

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.

The minimal record requirements satisfying department standards for ASTC services are as follows:

- **billing records** - ASTC copies of the UB-04 invoice and any other billing forms, supporting documents and forms, charge slips, itemized patient bills, patient ledger accounts and other business and accounting records referring to specific claims.
- **patient specific orders** - ASTC services or tests must be specifically ordered by the physician responsible for the care and treatment of the patient. This physician is required to sign all applicable sections for each test ordered in the appropriate place in the medical record. The order must be legible and explain completely all services or tests to be performed.

In addition to the above, the ASTC must maintain complete, comprehensive and accurate medical records to ensure adequate patient care that includes, but is not limited to the following:

- Patient identification;
- Significant medical history and results of physical examination;
- Preoperative diagnostic studies (entered before surgery), if performed;
- Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body or state law;
- Any known allergies and abnormal drug reactions;
- Entries related to anesthesia administration;
- Documentation of properly executed informed patient consent;

- Discharge diagnosis;
- Medications ordered and administered; and
- Medical records - utilization review committee reports, physicians' certifications and recertifications, discharge abstracts, discharge summaries, clinical and other medical records relating to program claims.

ASTC medical records must contain the dates of service and the name of the medical practitioner seeing the patient at the time of each ASTC visit.

The ASTC agrees to furnish to the department, upon request, information necessary to establish payment rates in the form and manner that the department requires.

Services provided in an ASTC may be subject to pre-payment and post-payment review to assess medical care, coding validation and quality of care. Medical records for participants covered under the department's medical programs must be made available to the department or its designated representative in the performance of utilization review.

Refer to Chapter 100 for information pertaining to the required retention period of medical records.

G-230 Covered Services

A covered service is a service for which payment can be made by the department. Refer to Chapter 100 for a general list of covered services under the department's Medical Programs.

ASTC services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook and 89 Illinois Administrative Code Section 146.

An ASTC may perform any surgical procedure approved by the individual facility's Consulting Committee and authorized under the Department of Public Health Rules under 77 Ill. Admin. Code Section 205.130. However, to qualify for outpatient payment, the procedure must be identified in HFS's Ambulatory Procedures Listing (APL).

G-230.1 Facility Services

Facility services furnished by an ASTC in conjunction with covered APL codes include, but are not limited to:

- Nursing, technician and related services;
- Use of the ASTC facility;
- Supplies such as drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances and equipment directly related to the provision of surgical procedures;
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- Administrative, record-keeping and housekeeping items and services; and
- Materials for anesthesia.

ASTCs shall not provide beds or other accommodations for the overnight stay of patients. However, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients up to 23 hours following admission. Individual patients must be discharged in an ambulatory condition without danger to the continued well-being of the patients or must be transferred to a hospital or similar environment.

Supplies and equipment used by the ASTC for the diagnosis or treatment of the patient during the ASTC surgical visit are included in the ASTC's all-inclusive rate.

Drugs dispensed for treatment or diagnostic purposes during the ASTC surgical visit shall be included in the approved per visit rate, and no separate charge can be made. Drugs dispensed for take home use as part of that ASTC surgical visit are also included in the approved rate and no separate payment will be made.

G-230.2 Non-Facility Services

Facility services do not include items and services that are paid under the fee-for-service payment methodology, such as physician services, laboratory, X-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery.

Services that are not considered facility services must be billed by the provider rendering such services on a fee-for-service basis. However, if the ASTC provides the lab or X-ray service, the facility may not bill separately if the lab or x-ray service was provided on the day of the surgery. The ASTC **may** bill separately if the lab or X-ray service was provided on a date other than the date of the surgery.

For services that may be billed as fee-for-service, ASTCs will be required to conform to the policies and billing procedures in effect for other providers of services. Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-ASTC setting.

Pharmacy Services

Drugs not covered as part of the ASTC visit must be dispensed in accordance with the requirements of the Illinois Pharmacy Practice Act. Information regarding participation requirements and enrollment procedures for the provision of pharmacy services may be obtained from the Provider Participation Unit. The ASTC cannot enroll separately as a pharmacy provider unless it agrees to provide pharmacy services to the general public.

Medical Transportation

An ASTC that owns and operates medical transportation vehicles as a separate entity, e.g., a private corporation, must enroll as a medical transportation provider under the appropriate provider type, e.g., ambulance service (Type 70), medicar service (Type 71), service car (Type 72), etc. The medical transportation claim must be made under the appropriate provider number.

The ASTC cannot enroll as a medical transportation provider unless it agrees to provide medical transportation services to the general public.

Charges for services are to be billed in accordance with the instructions in the Medical Transportation Handbook. Information regarding application and enrollment may be obtained from the Provider Participation Unit.

G-240 Non-Covered Services

Certain services are not covered in the scope of the Medical Assistance Program and payment cannot be made for their provision to participants. Refer to Chapter 100 for a general list of non-covered services.

Procedures performed by the ASTC that are not included as an approved code in the APL are not reimbursable as a facility service by the department.

G-250 ASTC Reimbursement System

The department will reimburse ASTCs for facility services in accordance with covered Ambulatory Procedures Listing (APL) codes. An outpatient ASTC claim must contain at least one procedure code listed in the APL. When any service listed in the APL is performed on a given day, all services provided on that day must be billed on a single outpatient institutional claim.

The all-inclusive EAPG PPS payment is considered to cover all services provided by salaried ASTC personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment on the ASTC premises, and all X-ray, laboratory and therapy provided to the patient on the same day.

G-250.1 Reimbursement for Non-Surgical Procedures and Non-Facility Services

Facility services do not include items and services for which payment may be made under other provisions, such as physicians' or dentists' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.

Laboratory, X-ray, prescription services, or other services in connection with a covered surgical procedure, which are not considered facility services, must be billed by the independent provider rendering the services. Payment will only be made to providers who are enrolled in the Illinois Medical Assistance Program as a provider of that service.

G-250.2 ASTC Reimbursement for Patients with Medicare Part B Coverage

G-250.2.1 Claims Containing an APL Procedure

If a claim does not automatically forward from the Medicare carrier to the department for adjudication, the ASTC must submit a Medicare crossover claim to the department on the paper HFS 3797 – Medicare Crossover Invoice, or its electronic claim equivalent on the Medical Electronic Data Interchange, Internet Electronic Claims (MEDI/IEC) System. Paper completion instructions are contained in the [appendices of the Handbook for Practitioner Services \(pdf\)](#). The Medicare allowed amount is compared to the department's maximum rate. The Medicare payment is subtracted from the lesser of the allowed amount or the department's maximum, and the resulting dollar amount is the department's payment. The department's liability will not exceed the deductible or coinsurance due.

Refer to the [Handbook for Practitioner Services](#) instructions for completion of the HFS 3797. Electronic claim submission via the Internet is available by registering on the department's [MEDI/IEC](#) System.

The HFS 3797 paper or electronic claim format is to be used only for claims that have been adjudicated in a payable status by Medicare. An ASTC claim that has been denied as non-covered by Medicare, but contains an appropriate APL procedure, should be sent to the department on the paper UB-04 with the denial notification attached. These claims should be sent to the following address for special handling:

Illinois Department of Healthcare and Family Services
P.O. Box 19128
Springfield, Illinois 62794-9128

G-250.2.2 Claims with No APL Procedure

If a claim does not automatically forward from the Medicare carrier to the department for adjudication, the ASTC must submit a Medicare crossover claim to the department on the paper HFS 3797 – Medicare Crossover Invoice, or its electronic claim equivalent on the MEDI/IEC System.

The Medicare allowed amount is compared to the department's maximum for each covered procedure. The Medicare payment is subtracted from the lesser of the allowed amount or the department's maximum, and the resulting dollar amount is the department's payment. The department's liability will not exceed the deductible or coinsurance due.

The HFS 3797 paper or electronic claim format is to be used only for claims that have been adjudicated in a payable status by Medicare. An ASTC claim that has been denied as non-covered by Medicare, and does not contain an appropriate APL procedure, should be sent to the department on the paper HFS 2360 with the denial notification attached. These claims should be sent to the following address for special handling:

Illinois Department of Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118.

G-254 Specialized Requirements for Certain Services

G-254.1 Hysterectomy

A hysterectomy is a covered service only when it is done for medical reasons, and is not done solely to accomplish sterilization. If there is more than one purpose to the procedure, the physician must certify that 1) the hysterectomy is not being performed solely to accomplish sterilization but is being performed for other medically necessary reasons **or** 2) one of the following exceptions applies:

1. Patient was already sterile at the time of the hysterectomy; or
2. Patient has a hysterectomy under a life-threatening emergency situation in which prior acknowledgment of receipt of hysterectomy information was not possible; or
3. Patient has a hysterectomy performed during a period of retroactive eligibility, and the patient was advised that the operation would render her permanently incapable of reproducing or exceptions 1 or 2 described above made such explanation unnecessary or impossible.

In accordance with federal regulations, payment can be made only if the information on the completed [Form 1977 Acknowledgement of Receipt of Hysterectomy Information](#) indicates that the patient was informed that the hysterectomy will render her permanently incapable of reproducing. **Completion of this form is required regardless of age.**

To ensure that requirements have been met, the physician who obtained the signed Form HFS 1977 must provide the ASTC with a copy, which should be reviewed by ASTC staff. The UB-04 claim (indicating a hysterectomy was performed) with the HFS 1977 attached can then be sent to the department for processing.

G-254.2 Sterilization Procedures Other Than a Hysterectomy

ASTC charges may be made for services associated with a sterilization procedure, other than a hysterectomy, only for individuals who have voluntarily given written informed consent, are at least 21 years old at the time consent is obtained and are not institutionalized or mentally incompetent. **At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.**

1. In the case of premature delivery, the sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on the consent form, as stated in 89 Ill. Adm. Code section 140.483. The informed

consent must also have been given at least 30 days before the **expected** date of delivery.

2. In the case of emergency abdominal surgery, at least 72 hours must have passed since the patient had given informed consent for the sterilization.

A patient has given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the patient to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the patient to be sterilized:
 - a. The patient was advised that she/he was free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the patient might be otherwise entitled;
 - b. The patient was counseled regarding available alternative methods of family planning and birth control, which are considered temporary;
 - c. The patient was advised that the sterilization procedure is considered to be irreversible;
 - d. The patient was given a thorough explanation of the specific sterilization procedure to be performed;
 - e. The patient was given a full description of the discomforts and risks that may accompany or follow the performing of that procedure, including an explanation of the type and possible effects of any anesthetic to be used;
 - f. The patient was given a full description of the benefits or advantages that may be expected as a result of the sterilization;
 - g. The patient was advised that the sterilization will not be performed for at least 30 days except in cases of premature deliveries or emergency abdominal surgery as indicated above.
2. Suitable arrangements were made to ensure that the information specified in (1) (a) through (g) was effectively communicated to any patient who is blind, deaf, or otherwise handicapped;
3. An interpreter was provided if the patient to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

4. The patient to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;
5. The consent form requirements specified below were met; and
6. Any additional requirements of State or local law for obtaining consent, except a requirement for spousal consent, were followed.

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

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

The patient's written consent for sterilization must be obtained on [Form HFS 2189 Sterilization Consent](#). All appropriate sections of the form are to be completed. **The HFS 2189 must be attached to the UB-04 billing form when charges are submitted.**

G-254.3 Abortion Services

Charges for an abortion and associated ASTC services are covered under the department's medical programs only when the mother's life is endangered, to end pregnancies resulting from rape or incest or if necessary, to protect a woman's health.

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

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

G-260 Payment Process

G-260.1 Charges

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

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

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

G-260.2 Claim Preparation and Submittal

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

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

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

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

For electronic claims submittal, refer to Topic G-260.7 below.

G-260.2.1 Split Bills (MANG - Spenddown)

See Chapter 100 for a full explanation of the spenddown policy.

Outpatient charges for a spenddown participant should be submitted to the patient's department of Human Services Family Community Resource Center (FCRC) for use in meeting the patient's spenddown obligation. The day on which the patient has incurred enough medical charges to meet the spenddown obligation is referred to as the Split Bill Day. FCRC staff will then provide the ASTC with an HFS 2432, Split Billing Transmittal, which must be submitted with any claim encompassing the Split Bill Day.

The Split Billing Transmittal will identify any patient liability amount the ASTC may collect from the patient. Providers must use the appropriate value code in the UB-04 Data Specifications Manual to identify the patient's spenddown liability. The value code must be utilized even if the patient's spenddown liability is zero.

HFS 2432s will not be issued for bills that are the total responsibility of the patient.

For billing purposes, ASTCs must also identify any other insurance payment applicable to services in each calendar month.

Any questions regarding calculation of spenddown should be directed to the FCRC serving the patient. For information on FCRCs, please refer to the [DHS website](#).

G-260.3 Payment

ASTC outpatient claims are processed through the EAPG grouper. Federal and state laws provide that payment by the department or its authorized agent constitutes payment in full. Providers are prohibited from seeking to collect amounts in excess of the department's payment from any other source, including the participant. This prohibition applies to payment made directly by the department and payments made on behalf of an eligible participant by a Managed Care Organization (MCO) under contract with the department. This does not affect the patient cost sharing as identified in Chapter 100.

Medicare/Medicaid Combination Claim Charges (“Crossover” Claims):

Medicare must first adjudicate claims for persons eligible for Medicare coverage. After adjudication by Medicare, the department will consider payment to the provider for deductible and coinsurance amounts due on bills on which Medicare benefits were paid. Medicare-covered ASTC services are billed to the department on the HFS 3797 Medicare Crossover Invoice.

If surgery services are denied by Medicare as non-covered, the ASTC must submit them to the department on the UB-04 claim form with the denial documentation attached.

If laboratory or radiology services are denied by Medicare as non-covered, the ASTC must submit them to the department as Medicaid fee-for-service on the HFS 2360 claim form with the denial documentation attached.

All claims adjudicated by the department will be identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the ASTC payee address on file with the department. Refer to Chapter 100 for payment procedures utilized by the department and for explanations of Remittance Advice detail.

G-260.4 Fee Schedule

A listing of allowable outpatient procedure codes is available on the department's website. This listing is termed the [Ambulatory Procedures Listing](#). A paper copy can be obtained by sending a written request to:

Illinois Department of Healthcare and Family Services
Bureau of Hospital and Provider Services
607 East Adams Street
Springfield, Illinois 62701

G-260.5 Post-Billing of Ancillary Charges

If a facility determines that an error was made in reporting the usual and customary charge for an ancillary service(s) on a claim due to late charges, corrective action may be taken, but only after the particular claim has been adjudicated in a payable status and reported on Form HFS 194-M-2, Remittance Advice. See Chapter 100, General Appendix 7 for an explanation of the information reported on the Remittance Advice form. Charges should only be submitted for those omitted from the original bill. Form Locator 4 Type of Bill Frequency Digit Code must be "5".

G-260.6 Payment Adjustments

General policy and procedures regarding payment adjustments are provided in Chapter 100. Chapter 100 also provides specific information concerning the use of the adjustment form as it pertains to institutional and fee-for-service claims. Providers are to use the HFS 2249 adjustment form for services previously paid on the institutional claim format and the HFS 2292 for services previously paid as fee-for-service.

Adjustments may be initiated only for a service for which payment has been made by the department and reported on the Remittance Advice. It cannot be used to correct a rejected service, to correct a suspended invoice or to correct erroneous ancillary services. Completed adjustment forms should be mailed to the following address at the department for processing:

Illinois Department of Healthcare and Family Services
P.O. Box 19101
Springfield, Illinois 62794-9101

G-260.6.1 Void/Rebill Mechanism

At this time, the department has not implemented the void/rebill process. The void/rebill mechanism utilizes Type of Bill Frequency Digit 7 (Replacement of Prior Claim) or 8 (Void/Cancel of Prior claim) to adjust a previously paid claim. Providers will be notified when the department is ready to accept these transactions.

G-260.7 Overpayments

Under federal regulations, the Medicaid agency (HFS) must take all reasonable measures to ensure that it is the payer of last resort. As part of the “Agreement for Participation in the Illinois Medical Assistance Program” upon enrollment in the Illinois Medical Assistance Program, the provider agrees to promptly notify the department of any overpayments of which the provider becomes aware. **The provider is responsible for identifying and repaying monies owed to the Department.** The department may suspend a provider’s payments, if the provider does not maintain accurate accounting for these payments.

G-260. 8 Electronic Claim Submittal

A service requiring an attachment cannot be billed electronically at this time. The specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, the provider should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data. Further information can be found in Chapter 100.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the 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. Refer to Chapter 100 for further details.

G-270 Ambulatory Services

Ambulatory services are defined as preventive, diagnostic, therapeutic, rehabilitative or palliative services provided in an ambulatory setting by or under the direction of a licensed practitioner. Ambulatory services include all services that do not require the formal admission of a participant to a hospital, including services provided in hospital outpatient departments, clinics as defined in 89 Ill. Admin Code section 140.461(a), and ASTCs.

Note - A claim that has been totally rejected for payment by Medicare may be submitted for payment consideration only when the reason for nonpayment is either that the patient was not eligible for Medicare benefits or the service is not covered as a Medicare benefit. In such instances, the department is to be billed only after final adjudication of the claim by the Medicare carrier or intermediary.

G-270.1 Ambulatory Procedures Listing (APL)

Certain procedures provided in the outpatient hospital or ASTC settings, which have been determined by the department to be either unique to or most appropriately provided in those settings, are contained in the Ambulatory Procedures Listing (APL).

The [APL](#) is available on the department's website. **Not all procedures will be applicable to the services provided in an ASTC.** The outpatient services reimbursed through the EAPG PPS include:

- **Surgical Services**
- **Diagnostic and Therapeutic Services**
- **Emergency Department Services**
- **Psychiatric Services**
- **Observation Services**

G-270.1.1 Observation Requirements

Observation is established to reimburse services that are provided when a patient's current condition does not warrant an inpatient admission, but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care.

Some patients, while not requiring hospital admission, may require an extended period of observation. Appropriate observation and appropriate ancillary services may be obtained as an outpatient to determine the patient's future medical management. While the continued outpatient observation period may be medically necessary, admission to the hospital may not be medically necessary. Observation services should be used only for patients who do not meet medical necessity for inpatient admission.

Facilities may utilize industry standard criteria as a tool to compare with the documentation present in the patient's medical record. The need for outpatient observation must be documented in the medical record. **The physician's orders should support the need for observation services and the corresponding nurses' notes should show that skilled observation has been furnished.**

ASTCs are required to code observation services with Revenue Code 0762 and an associated HCPCS code as identified in the APL, and note the number of hours in observation in FL 46 – Service Units. Additionally, providers must code a second Revenue Code 0762 line and identify HCPCS code G0378 in order for observation services to process correctly. The minimum billable observation time is one hour.

G-270.2 Expensive Drugs and Devices

For outpatient dates of service through June 30, 2014, an ASTC may be eligible for an additional payment called an "outlier" payment for specified expensive drugs and devices provided in an outpatient setting, in addition to the APL service. Those drugs and devices are identified in the [Expensive Drugs and Devices Listing](#) on the department's website.

Medicare/Medicaid crossover claims will not be eligible for an outlier payment.

To be eligible for an outlier payment, the drug or device:

1. Must be medically necessary for the patient; and
2. May be subject to prior approval by the department

If any drug or device requires prior approval, it will be noted in the Expensive Drugs and Devices Listing with a link to the appropriate approval form:

- A drug approval request must be submitted on Form HFS 3082, Request for Drug Prior Approval,
- A device approval request must be submitted on Form HFS 1409, Prior Approval Request form.

Both forms are also available on the department's [Medical Forms page](#) of the website.

The provider will receive written notification of the department's decision. The provider must render the approved service within thirty days from the date of approval by the department. All prior approval requests must be mailed or faxed to the department; no telephone requests will be accepted. The department will accept requests for post approval for consideration, but approval is not guaranteed.

G-276 Reporting of National Drug Codes (NDCs)

Federal law requires Medicaid programs to collect rebates from drug manufacturers on claims for outpatient drugs, including claims billed by non-pharmacy providers, as part of the Medicaid Drug Rebate Program. In order for the department to collect rebates, the claims must contain accurate NDCs and the quantity of the drug administered at an NDC level. Effective with dates of service on and after July 1, 2014, ASTCs are required to identify the NDCs in FL 43 for **all** outpatient drugs billed.

It sometimes may be necessary for providers to bill multiple NDCs for a single HCPCS code. This may happen when two different strengths of the same drug are needed in order to administer the appropriate dose. This will also be necessary when multiple vials of the same drug are used to administer the appropriate doses, and the vials are manufactured by different manufacturers. When a provider uses more than one NDC for a drug, the provider must include all NDCs on the claim.

For “Through” dates of service prior to July 1, 2014, providers are required to detail revenue code line reporting when billing for more than one NDC per HCPCS code **in conjunction with revenue codes 0634, 0635, and 0636**. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting.

Effective with “Through” dates of service July 1, 2014 and after, providers are required to detail revenue code line reporting when billing for more than one NDC per HCPCS code **in conjunction with any revenue code**. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting.