



Handbook for Providers of Hospital Services

Chapter H-200 Policy and Procedures For Hospital Services

Illinois Department of Healthcare and Family Services

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Chapter H-200

Hospital Services

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Foreword

Purpose

This handbook has been prepared for the information and guidance of providers who provide hospital services to participants in the department's Medical Programs. It also provides information on the department's requirements for provider participation and enrollment.

This [handbook](#) can be viewed on the department's Web site.

This handbook provides information regarding specific policies and procedures relating to hospital inpatient and outpatient services. It also contains policy and procedures relating to outpatient renal dialysis treatment provided by hospitals, hospital satellite renal dialysis clinics, and freestanding renal dialysis facilities. 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 Web site.

Providers will be held responsible for compliance with all policy and procedures contained herein.

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

=Definitions

Effective June 15, 2011

ARS - Alternate Reimbursement System is an inpatient per diem rate based on the hospital's allowable operating cost and other costs reimbursed on a per diem basis, and applicable adjustments.

=All-Inclusive Rate - A specified rate that includes all services provided in an inpatient or outpatient setting for each day a patient is treated. The all-inclusive rate is considered to cover all services provided by salaried hospital personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment, and all X-ray, laboratory and therapy provided to the patient on the same day. Exceptions to this are:

Reimbursement can be made for the professional outpatient service of a physician salaried by the hospital that is involved with direct patient care. This excludes billing for services by radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists.

Occupational or speech therapy, or both, may be billed separately if provided in conjunction with physical rehabilitation services.

Certain covered injectable drugs, including but not limited to Epogen and Aranesp, administered in conjunction with outpatient renal dialysis treatment, are reimbursed as an add-on payment.

[Expensive drugs and devices](#) that are provided in conjunction with a service from the APL may be reimbursable. Refer to the department's Web site for a listing of the applicable drugs and devices codes with their corresponding Ambulatory Procedures Listing (APL) codes.

Procedures provided in an outpatient setting must be included on the APL to be paid at the all-inclusive rate. (For the definition of APL, see below). If the procedure is not included, the service must be billed as fee-for-service.

[Ambulatory Procedures Listing \(APL\)](#) - A listing of procedures that has been determined by the department to be either unique to or most appropriately provided in the hospital outpatient or ambulatory surgical treatment center setting.

Cost-Reporting Hospital - All Illinois hospitals enrolled with the department of Healthcare and Family Services must file Medicaid and Medicare cost reports. All hospitals in states contiguous to Illinois providing 100 or more inpatient days of care to Illinois Medicaid patients, or that elect to be reimbursed under DRG payment methodology, must file Medicaid and Medicare cost reports.

DRG-PPS - Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) method of inpatient reimbursement. This method of reimbursement is calculated on a per discharge basis, and is patterned after Medicare's method of payment.

Emergency Services - Those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the department shall be based on circumstances at the time of initial examination, not upon the final determination of the patient's actual condition, unless the actual condition is more severe.

Emergency Level I (Revenue Code 0450) - Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function. Claims must be billed using one of the specified CPT codes for Emergency Level I services identified in the [APL](#) Group Order document on the Web site.

Emergency Level II (Revenue Code 0456) - Emergency Services that do not meet the definition of Emergency Level I care, but which are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity that urgent or unscheduled care is required. Claims must be billed using one of the specified CPT codes for Emergency Level II services identified in the APL Group Order document at the Web site above.

Non-Emergency/Screening Level (Revenue Code 0451) - Those services provided in the hospital emergency department that do not meet the requirements of Emergency Levels I or II. For such care, the department will reimburse the hospital either applicable current fee for service rates for the services provided **or** a screening fee, but not both. Institutional claims must be billed using a specified CPT code for Non-Emergency/Screening Level services identified in the APL Group Order document at the Web site above.

Fee-for-Service (FFS) - A payment methodology for certain services provided in hospital outpatient settings for which the hospital must conform to the policies and billing procedures for other non-hospital providers of services. Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-hospital-based setting. Medicare crossover claims billed on the institutional claim format are excluded. Refer to Topic H-201.12.

=Hospital-based Organized Clinics – Hospital-based organized clinics must meet the requirements as stated in Ill. Adm. Code Section 140.461(a). This includes being physically located within a 35-mile radius of the main hospital campus as defined in 42 CFR Part 413.65.

Inpatient Services - Those services provided to a patient whose condition warrants formal admission and treatment in a hospital, and that are reimbursed based on the per diem or per discharge all-inclusive rate.

Institutional Claim format – Claims prepared in the 837I or Direct Data Entry (DDE) electronic formats or UB-04 paper claim format.

Long Term Stay Hospital - Hospitals that have an average length of inpatient stay which exceeds 25 days and are determined to provide long term acute care. These hospitals are exempt from the DRG methodology and receive reimbursement under an alternate reimbursement system (ARS) methodology. An example of a service provided by a long term stay hospital is ventilator care. The term "long term stay hospital" does not include a psychiatric, rehabilitation, or children's hospital.

National Drug Code (NDC) - A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. The National Drug Code (NDC) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

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).

Non-Cost Reporting Out-of-State Hospital - A hospital in a state other than Illinois that is not required to file Medicaid and Medicare cost reports with the department. Non-cost reporting out-of-state hospitals are exempt from DRG payment methodology.

Psychiatric Clinic Type A Services - Type A psychiatric clinic services are clinic services packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional electroconvulsive therapy (ECT); and counseling, provided in the hospital clinic setting. Claims must be billed using one of the specified procedure codes for Psychiatric Clinic Type A services identified in the [APL](#) Group Order document on the Web site.

Psychiatric Clinic Type B Services - Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12-month period. Claims must be billed using a specified procedure code for Psychiatric Clinic Type B services identified in the [APL](#) Group Order document.

SASS - Screening, Assessment and Support Services (SASS) program. This program is a result of the Children's Mental Health Act of 2003, which requires the Department of Healthcare and Family Services (HFS) to ensure that all eligible children and adolescents receive a screening and assessment prior to any admission to a hospital for inpatient psychiatric care. Refer to Topic H-268 for additional information.

Chapter H-200

Hospital Services

H-200 Basic Provisions

For consideration for payment by the department for hospital or renal dialysis services, a provider 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 Web site 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. Providers billing the inpatient, outpatient, and renal dialysis 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 the [Chapter 300](#), Handbook for Electronic Processing found on the department's Web site.

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

H-201 Provider Participation

H-201.1 Participation Requirements

To participate in the department's Medical Programs, a hospital must meet the definition of a hospital as defined in 89 Ill. Adm. Code 148.25 and 148.30, as well as the requirements of Topic H-201.1 through Topic H-201.5. Requirements that must be met for enrollment to provide specific hospital categories of service are covered in this topic in category of service order. Special information on enrolling for fee-for-service categories of service is shown in Topic H-201.12.

The following requirements must be met by a hospital to qualify for enrollment:

- The hospital must comply with the participation requirements stated in Chapter 100, Topic 101.1.
- The hospital must hold a valid appropriate license issued by the state in which the hospital is located. If a hospital is located in Illinois, the hospital must be licensed under the Hospital Licensing Act or the University of Illinois Hospital Act;
- The hospital must be certified by the Social Security Administration for participation in the Medicare Program (Title XVIII); or if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO);
- The hospital must agree to provide equal access to available services to low income persons, and must agree to provide data and reports on the provision of such care as required by the department;
- All hospitals in Illinois, those hospitals in contiguous states providing 100 or more inpatient days of care to Illinois participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code, Section 149 (the DRG Prospective Payment System), must file Medicaid and Medicare cost reports within 150 days of the close of that provider's fiscal year. To participate, a hospital 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)

The following documentation must also be provided with the application:

- A copy of the facility medical license
- A copy of the valid Clinical Laboratory Improvement Amendments (CLIA) certificate
- A copy of the Medicare certification letter

These [forms](#) may be obtained from the department's Web site. Providers may also request the enrollment forms by [e-mail](#).

Providers may call the 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 Chief Executive Officer of the hospital, and returned to the above address. The hospital should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the hospital requests a specific enrollment date and it is approved by the department.

Participation approval is not transferable. Refer to Topic H-201.3

H-201.11 Inpatient and Outpatient Hospital Categories of Service

A hospital must be enrolled for the specific category of service (COS) for which charges are to be made. The categories of service for which a hospital may enroll are:

COS	Service Definition
020	Inpatient Hospital Services (General)
021	Inpatient Hospital Services (Psychiatric)
022	Inpatient Hospital Services (Physical Rehabilitation)
024	Ambulatory (Outpatient) Hospital Services (General)
025	Ambulatory (Outpatient) End Stage Renal Disease Services
027	Ambulatory Services (Psychiatric Clinic Type A)
028	Ambulatory Services (Psychiatric Clinic Type B)

029 Ambulatory Services (Physical Rehabilitation)

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

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

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

Effective May 16, 2011

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

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

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

COS Service Definition

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

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

012 Occupational Therapy Services

013 Speech Therapy/Pathology Services

014 Audiology Services

017 Anesthesia Services

030 Healthy Kids Services

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

H-201.13 Services Requiring Special Enrollment

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

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

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

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

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

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

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

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

Hospitals with a hospice program must enroll the program separately as a hospice agency. Refer to the Handbook for Hospice Agencies for more information.

H-201.2 Enrollment Requirements for Specific Hospital Categories of Service

H-201.21 General Inpatient Services - Category of Service 20

To be eligible for enrollment for the provision of general inpatient services, a hospital must meet the criteria as set forth in Topic H-201.1.

Hospitals may participate in the department's Medical Programs and receive payment for the provision of general inpatient hospital services under applicable department rules contained in 89 Ill. Adm. Code, Sections 148.10 through 148.400 and Sections 149.25 through 149.150.

H-201.22 Inpatient Psychiatric Services – Category of Service 21

To be eligible for enrollment for the provision of inpatient psychiatric services, a hospital must be:

1. A participating general hospital with a distinct part unit of the hospital that specializes in psychiatric services; or
2. A hospital that holds a valid license as a psychiatric hospital and complies with the requirements stated in Topic H-201.1.

A psychiatric hospital must be accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) to provide services to patients under age 21. A psychiatric hospital must be Medicare-certified to provide services to patients ages 65 and over.

Hospitals located within the State of Illinois and within a 100-mile radius of the State of Illinois must meet the requirements established by the Illinois Department of Human Services (DHS) and must execute a Coordination of Care Agreement with a DHS-operated mental health center for coordination of services, including but not limited to crisis screening and discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services.

The department will make the necessary contacts with the Department of Human Services (DHS) for the Coordination of Care Agreement. Hospitals located beyond a 100-mile radius of the State of Illinois are not required to execute an agreement with a DHS-operated mental health center for coordination of services, but must comply with all other requirements as stated in their enrollment letter.

H-201.23 Inpatient Physical Rehabilitation Services – Category of Service 22

To be eligible for the provision of inpatient physical rehabilitation services, a hospital must be either:

1. A participating general hospital with a distinct part unit of the hospital that specializes in physical rehabilitation services; or
2. A hospital that holds a valid license as a physical rehabilitation hospital.

A hospital that specializes in or has a distinct part unit that specializes in physical rehabilitation services must comply with requirements stated in Topic H-201.1. To provide physical rehabilitation services, a hospital must meet specific criteria as described in the Physical Rehabilitation Facilities Evaluation Form. This form may be requested from the Provider Participation Unit.

H-201.24 Ambulatory Services – Category of Service 24

When a hospital is enrolled for general inpatient services, the department automatically enrolls the hospital for the provision of general outpatient services.

H-201.25 Ambulatory End Stage Renal Disease Treatment – Category of Service 25

Hospitals and freestanding dialysis centers are eligible to enroll for the provision of outpatient renal dialysis services. Services may be provided in the outpatient renal dialysis department of a hospital, a satellite unit of a hospital, a freestanding dialysis center, or where a patient resides.

Special enrollment is required for the provision of ambulatory renal dialysis services. Enrollment to provide renal dialysis services is approved by the department when the facility submits:

- Form HFS 2243 (Provider Enrollment Application Form)
- Form HFS 1413 (Agreement for Participation)
- Form HFS 1513 (Enrollment Disclosure Statement)
- A copy of the Medicare Certification
- A copy of the letter with the rate of reimbursement determined by the Centers for Medicare and Medicaid Services (CMS)
- W-9 (Request for Taxpayer Identification Number)

Each satellite unit located apart from the hospital and each freestanding dialysis center must submit an application and all specific documentation.

When Medicare rates for dialysis services are revised, it is the facility's responsibility to notify the Provider Participation Unit by forwarding a copy of the Medicare rate letter to the Provider Participation Unit.

=H-201.26 Psychiatric Ambulatory Services – Categories of Service 27 and 28

Effective June 15, 2011

To be eligible for the provision of psychiatric ambulatory services, a hospital may request to enroll for Type A and/or Type B psychiatric ambulatory services when they are enrolled for inpatient psychiatric services. Additionally, a hospital that was previously enrolled with the department for the provision of inpatient psychiatric services on or after June 1, 2002, but is no longer enrolled, may request to be enrolled for ambulatory psychiatric services only. The hospital must, as stated in Ill. Adm. Code Section 140.461(a):

1. Have a hospital-based organized clinic with an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care;
2. Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the department, for the acquisition of these services through contractual arrangements with external medical providers;
3. Meet the following requirements:
 - Be located adjacent to or on the premises of the hospital and be licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or
 - Have provider-based status under Medicare pursuant to 42 CFR 413.65; or
 - Be clinically integrated as evidenced by the following: professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system (or cross reference) of the main hospital; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main hospital; and
 - Be fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic; and
 - Be held out to the public and other payers as part of the main hospital; and

- Be operated under the ownership and control of the main hospital, as evidenced by the following: the business enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic; and
- Be located within a 35 mile radius of the main hospital campus as defined in 42 CFR Part 413.65.

4. Meet the applicable requirements of 89 Ill Adm. Code 148.40(d) for Psychiatric Clinic services.

To enroll for the provision of psychiatric ambulatory services, a hospital must request the Psychiatric Ambulatory Services Type A and B Enrollment Assurances Form. This form and a copy of the entire enrollment packet must be sent by the hospital to the Department of Human Services for approval. The address is:

Illinois Department of Human Services
Division of Mental Health
319 East Madison, Suite 3B
Springfield, Illinois 62701

If a hospital is already enrolled with the department, and later wants to add psychiatric services to its billable categories of service, the hospital must contact the Provider Participation Unit.

H-201.27 Physical Rehabilitation Ambulatory Services – Category of Service 29

A hospital may request to enroll for physical rehabilitation ambulatory services when they are enrolled for Inpatient Physical Rehabilitation Services. To be eligible for the provision of Physical Rehabilitation Ambulatory Services, the rehabilitation facility must comply with the requirements of Items 1, 2, and 3 of Topic H-201.26, and 89 Ill. Adm. Code Section 148.40(d) for Rehabilitation Clinic services.

H-201.3 Participation Approval

When participation is approved, the hospital 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 H-1.

If all information is correct, the hospital 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 H-201.5.

Except for Category of Service 24, base rates will be shown on the Provider Information Sheet. Payment for Category of Service 24 is based upon the applicable outpatient-billable procedure code from the Ambulatory Procedures Listing (APL) or the applicable revenue code for emergency department or observation services.

When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. In instances in which a hospital has more than one associated renal dialysis facility, a separate Provider Information Sheet will be sent for each unit. In those instances in which a dialysis facility is located within another hospital, and the cost is allowed to the parent hospital, a separate enrollment is generated for that facility. The payee may be either the parent hospital or that facility's office. A separate Provider Information Sheet will be produced for the facility.

In instances in which two or more hospitals have the same FEIN number, but the entity owning the hospitals has separate Medicare certifications for those hospitals, the hospitals will be enrolled separately and a Provider Information Sheet will be prepared for each location showing the unique HFS provider number assigned. Appropriate data, as indicated above, will be listed for all categories of service that may be provided at the specific location.

If two or more hospitals are certified under a single Medicare number, the hospitals must be enrolled as a single hospital in the Medical Assistance Program (see 89 III. Adm. Code Section 140.11). This excludes children's hospitals as defined in 89 III. Adm. Code Section 149.50 (c)(3).

H-201.4 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 hospital 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 III. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 III. Adm. Code 104 Subpart C.

H-201.5 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 lineout the incorrect or changed data, enter the correct data, 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.

H-202 Record Requirements and Audits

The department regards the maintenance of adequate medical records as 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, Topic 110 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.

Hospitals are also responsible for maintaining the following information related specifically to hospitals:

- Cost Report records - All data to support the accuracy of the entries on the annual cost reports, including original invoices, canceled checks, work papers used in preparing annual cost reports and contracts or records of association with outside sources of medical supplies and services or with related organizations (see Topic H-203 regarding cost reports);
- Medical Assistance logs - Logs must be kept by Medical Program in auditable form showing patient name, dates of admission and discharge, number of days by type of service, ancillary charges by department, total charges and payments by payer. A separate log must be kept for the hospital and each distinct part unit; and
- Medical Records - Utilization review committee reports, physicians' certifications and recertifications, discharge abstracts, discharge summaries, clinical and other medical records relating to program claims.

H-202.1 Patient Specific Orders and Ancillary Services and Tests

Ancillary services and routine tests (those services other than routine room and board and nursing, which are required because of the patient's medical condition, including lab tests and X-rays) shall not be covered unless there is a patient specific written order for the test from the attending or operating physician responsible for the care and treatment of the patient. The attending or operating physician responsible for the care and treatment of the patient 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. Standing orders are not acceptable.

Upon completion of the service or test, a fully documented description of results with findings, or the administration of medication, must be maintained in the patient medical records. Radiological services must have the actual X-rays and the interpretation report; laboratory/pathological tests must have the specific findings for each test; drugs and pharmaceutical supplies must indicate strength, dosages and duration.

Charges for any and all such services or tests cannot exceed those charged to the general public. The failure to maintain and provide records as described above will result in the disallowance of the applicable charges upon audit. It is the responsibility of the hospital to ensure the proper maintenance of these records and the hospital's responsibility to provide them upon request by or on behalf of the department.

H-202.2 Pre-Operative Days

For hospitals which are reimbursed for services by other than the DRG reimbursement methodology, reimbursement will be allowed for no more than one inpatient hospital day, with the exception of bone marrow/stem cell transplants, prior to the date of surgical procedure, unless the attending physician determines that the exception is medically necessary. In such cases, the attending physician must document the medical necessity and include a brief explanation justifying the medical necessity in the patient's medical record. **All** inpatient days must be medically necessary.

H-203 Cost Reports

H-203.1 Hospitals Required to Submit Cost Reports

Cost reports are required from:

- All hospitals within the State of Illinois;
- All out-of-state hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois Medicaid patients; and
- All out-of-state hospitals in contiguous states that elect to be reimbursed under the DRG-PPS.

The department's payment rate to all Illinois hospitals and all out-of-state hospitals required to submit cost information is individualized by hospital and is based on reasonable costs which do not exceed the reimbursement under Title XVIII (Medicare) methods of apportionment. Costs not allowable under Title XVIII are not considered in determining rates under Title XIX (Medicaid).

The payment system for these hospitals is a prospective rate setting system with payment based on the hospital's annual Medicaid cost report(s) as filed by the hospital and audited by the Illinois Department of Healthcare and Family Services, Bureau of Health Finance (BHF). Cost analysis by that office or its authorized agent provides the information necessary to establish prospective payment rates for hospital services.

The approved rate and the effective date, appropriate for the category of service the hospital is enrolled to provide, are shown on the Provider Information Sheet. The rate paid to the hospital for services rendered to participants will be the appropriate rate in effect for the category of service on the date the service was provided. When a new rate is approved, an updated Provider Information Sheet will be sent to the hospital showing the new rate and the effective date.

Upon a hospital's approval for participation in the Medical Assistance Program, BHF will supply the appropriate forms and instructions for completion of the Medicaid cost report(s).

Directions for maintaining the required hospital logs for Medicaid inpatient services reimbursed by the Department of Healthcare and Family Services will be provided by that bureau.

Hospitals must include all zero balance billings in the cost report.

Cost reports must be submitted annually, within 150 days of the close of the hospital's fiscal year. No extension of the Medicaid cost report due date will be granted by the department unless the Centers for Medicare and Medicaid Services (CMS) grants an extension for the Medicare report. Should CMS extend the Medicare report due date, the Medicaid report due date would coincide with the Medicare report.

Any hospital certified in the Medicare Program (Title XVIII) electing, for the first time, to be reimbursed under the DRG-PPS, must include a copy of each of the two most recently audited Medicare reports at the time of enrollment.

The Medicaid cost report must be completed and submitted for each of the programs for which the hospital is reimbursed by the State of Illinois. The [cost report and instructions](#) can be downloaded from the department's Web site.

The completed Medicaid report(s) with a copy of the hospital's Medicare cost report and audited financial statement must be submitted for review as directed by BHF. If the cost information is not submitted on a timely basis, the Department of Healthcare and Family Services will temporarily suspend processing of any bills from hospitals whose cost reports are delinquent. The processing of bills will resume after the cost report is received and reviewed by BHF.

Written inquiries regarding the preparation and submittal of the cost statement are to be directed to:

Illinois Department of Healthcare and Family Services
Prescott Bloom Building
Bureau of Health Finance - Hospital Audit Supervisor
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Telephone inquiries are to be directed to 217-782-1630.

H-203.2 Hospitals Exempt from Submittal of Cost

Participating out of state hospitals providing less than 100 Illinois Medicaid days per year, that do not elect to receive, or are exempt from, reimbursement under the DRG-PPS, are exempt from submitting cost information. Rates are established by the department for payment of participants' care based upon the aggregate average rates for hospitals that are required to submit cost information, as outlined in 89 Ill. Adm. Code, Section 148.270.

H-211 Determination of Need for Services

H-211.1 Patient Application in the Hospital Setting

Due to the number of individuals who experience their first need for medical assistance while receiving services in a hospital inpatient setting, and the need to expedite the processing of applications, hospitals may use Form 2378H *Mail-In Application for Medical Benefits* for patients who wish to apply for medical assistance. A supply of these forms can be obtained from any Department of Human Services (DHS) Family Community Resource Center (FCRC) and should be maintained by the hospital. For information on the Family Community Resource Centers, please refer to the [DHS Web site](#). The DHS Office Locator can be found by scrolling to the bottom of the DHS Web page.

Hospitals may also enroll as All Kids Application Agents (AKAAs), to help families to apply for All Kids, Family Care and Moms & Babies (see Chapter 100 for definitions of these programs). AKAAs are eligible to receive Technical Assistance Payments (TAP). A TAP is issued for each completed application that meets the department's criteria and results in new coverage. Requirements for becoming an [AKAA](#) are on the department's Web site.

Although hospital personnel may assist the patient in completing an application, the request for assistance is made by or for the patient and the resulting rights and obligations are those of the applicants. The decision as to whether or not an application is to be submitted is the choice of the applicant.

H-211.2 Newborn Enrollment

A Newborn Unit has been established in the Department of Human Services to expedite authorization of medical assistance for newborns added to the medical assistance case, and if applicable, to initiate the establishment of paternity. Hospitals are encouraged to complete the Record of Birth (Form 2636) and, if applicable, the Voluntary Acknowledgement of Paternity (HFS 3416B) while the mother is still in the hospital and fax the form(s) immediately to the Newborn Unit. This can substantially reduce the time involved in getting the child medical coverage, thereby reducing delays in claims processing. The fax number is 217-524-5571.

NOTE: If a hospital has faxed the Voluntary Acknowledgement of Paternity (HFS 3416B) to the Newborn Unit, the hospital must also mail it to:

Central Child Support Office
Bureau of Administrative Operations
Administrative Coordination Unit
110 West Lawrence
Springfield, Illinois 62704

H-211.3 Voluntary Acknowledgement of Paternity

State law requires hospitals, at the time of the birth of a child, while the mother and child are still in the hospital, to provide unmarried parents an opportunity to establish paternity through the Voluntary Acknowledgment of Paternity process. This is a voluntary process and the forms utilized are legal forms. Hospitals are required to provide written materials and an oral explanation of the implications of, alternatives to, legal consequences of, and the rights and responsibilities of signing the Voluntary Acknowledgement of Paternity, such as child support, retroactive support, reimbursement of public assistance, health insurance coverage, and medical costs.

Additional information regarding this process can be found by viewing the [Division of Child Support Enforcement](#) section on the department's Web site.

H-230 Covered Services

A covered service is a service for which payment can be made by the department. Refer to Chapter 100, Topic 103, for a general list of covered services.

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

The department reimburses hospitals for medically necessary inpatient and outpatient diagnostic and treatment services that are provided to participants covered under the department's medical programs. These services must be provided in compliance with hospital licensing standards. Payment may be made for the following types of care (subject to the special requirements described in 89 Illinois Administrative Code Section 148.40):

1. General/specialty services
2. Psychiatric services
3. Rehabilitation services
4. End-Stage Renal Disease Treatment (ESRDT) services

Certain programs are administered as hospital covered services with specific restrictions. These services are further explained in Topic H-254.

H-240 Hospital-Related Services Not Covered Under the Department's Medical Programs

The department does not cover services for which medical necessity is not clearly established. See Chapter 100, Topic 104, for services and supplies for which payment will not be made.

Additionally, the following hospital services are excluded from coverage and payment cannot be made for the provision of these services:

- Care provided by or in federal hospitals;
- Care provided by a hospital located in Illinois that is not enrolled in the Medical Assistance Program;
- Diagnostic or therapeutic procedures related to fertility treatment or reversal of sterility.
- Services associated with a hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing (see Topic H-254.51 for additional clarification);
- Swing-bed post-hospital skilled nursing care;
- Services associated with examinations required for the determination of eligibility for assistance. Local Department of Human Services offices may request that these examinations be provided with payment from non-medical funds. Hospitals are to follow specific billing procedures given when such a request is made;
- Services associated with injection or implantation of a prosthesis which does not increase physical capacity, overcome a handicap, restore a physiological function, or eliminate a functional disability (NOTE: Does not apply to breast prosthetic devices provided following cancer surgery);
- Other services not covered by Title XIX in the hospital setting.

H-250 Reimbursement System

H-250.1 Inpatient Reimbursement Methodologies

Payment to hospitals for inpatient care is based on the reimbursement methodology in effect at the time of service. This methodology is outlined in applicable department rules in 89 Ill. Adm. Code, Sections 148.10 through 148.400, and Sections 149.25 through 149.150.

There are five possible inpatient payment methodologies:

1. DRG-PPS - Diagnosis Related Grouping-Prospective Payment System (DRG-PPS) pays per discharge based upon the group into which the diagnosis code is placed. Hospitals are paid a predetermined all-inclusive per discharge rate.
2. Excluded or Exempt Hospitals and Distinct Units - Certain hospitals and units of hospitals are excluded or exempt from DRG-PPS and are paid at a per diem rate calculated by the department in accordance with applicable rules set forth in 89 Ill. Adm. Code, Section 148. The exempt hospitals and distinct part units are listed below with the applicable administrative rule citation noted in parentheses.

Excluded or Exempt Hospitals include:

- psychiatric hospitals (89 Ill. Adm. Code, Section 148.260)
- rehabilitation hospitals (89 Ill. Adm. Code, Section 148.260)
- children's hospitals (89 Ill. Adm. Code, Section 148.280)
- long-term stay hospitals (89 Ill. Adm. Code, Section 148.260)
- hospitals outside Illinois that are excluded or exempt from cost reporting requirements and do not elect to receive, or are excluded or exempt from, reimbursement under the DRG-PPS (89 Ill. Adm. Code, Section 148.270)
- Sole Community hospitals that do not elect to receive, or are excluded or exempt from, reimbursement under the DRG-PPS (89 Ill. Adm. Code, Section 148.260)
- hospitals reimbursed under special arrangements (89 Ill. Adm. Code, Section 148.280)
- county-owned hospitals (89 Ill. Adm. Code, Section 148.160)
- State-owned hospitals (89 Ill. Adm. Code, Section 148.170)

Excluded or Exempt Distinct Part Hospital Units

- psychiatric units (89 Ill. Adm. Code, Section 148.270)
- rehabilitation units (89 Ill. Adm. Code, Section 148.270)

3. ARS - Alternate Reimbursement System is a per diem payment methodology. Claims are paid based on the length of stay at the ARS rate. The ARS calculation is based on the individual hospital's cost report and utilization. This rate is all-inclusive.
4. Non-cost-based per diem rate - Hospitals that were contracting under the old Illinois Competitive Access and Reimbursement Equity (ICARE) program were allowed to choose to retain their ICARE contracted rate(s). The ICARE program was effective through August 31, 1991.
5. Transplants - Transplants (excluding kidney and cornea) are reimbursed according to 89 Ill. Adm. Code 148.82.

H-250.2 Department Institutional Co-Payments/Coinsurance

When billing the department, providers should bill their usual and customary charge and **should not** report the co-payment or coinsurance on the claim. The department will automatically deduct the co-payment or coinsurance. The Remittance Advice will reflect the amount of the co-payment or coinsurance withheld by the department.

Federal regulations stipulate that a provider cannot deny services to an individual covered under Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of the Social Security Act due to the person's inability to pay a co-payment. This requirement does not apply to All Kids Premium Levels 2 through 8 and Veterans Care. Providers may apply their office policies relating to the co-payments and coinsurance to participants covered under All Kids Premium Levels 2 – 8 and Veterans Care.

Outpatient renal dialysis treatment (Category of Service 25), psychiatric clinic Type A and Type B services (Categories of Service 27 and 28), outpatient rehabilitation services (Category of Service 29), and subacute alcohol and substance abuse treatment services (Category of Service 35) **are exempt from coinsurance assessment.**

H-250.21 Title XIX Inpatient Co-Payments

Title XIX (Medicaid) participants ages 19 and older (excluding the patient populations in 89 Ill. Admin. Code 140.402) will be assessed copayments on inpatient hospital services in the following amounts:

- Inpatient hospital services paid under DRG-PPS methodology (as described in 89 Ill. Adm. Code, Section 149) - \$3.00 per day.
- Inpatient hospital services in hospitals with an alternate cost per diem rate (as described in 89 Ill. Adm. Code, Section 148.270) of \$325.00 or more - \$3.00 per day.

- Inpatient hospital services in hospitals with an alternate cost per diem rate (as described in 89 Ill. Adm. Code, Section 148.270) of more than \$275 but less than \$325 - \$2.00 per day.
- Inpatient hospital services in hospitals with an alternate cost per diem rate (as described in 89 Ill. Adm. Code, Section 148.270) of \$275 or less - no co-payment.

H-250.22 Other Institutional Co-payments/Coinsurance

Medical programs such All Kids Share and Premium Level 1, All Kids Expansion Levels 2 through 8, and Veterans Care, require inpatient and outpatient co-payments or coinsurance. These are identified in Chapter 100, General Appendices 12, 13, and 14.

All Kids Premium Levels 2 Through 8 and Veterans Care Claims

Inpatient Claims –The department assesses a co-payment only to an admission through discharge claim (Type of Bill Frequency Digit of “1”), or the initial claim in a continuing series (Type of Bill Frequency Digit of “2”). For patients in one of the levels requiring a percentage coinsurance based on the HFS rate per admission, the department assesses the coinsurance to all bills submitted.

Claims containing a Source of Admission “D” (Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer) or Source of Admission “4” (Transfer from a Hospital Different Facility) will not be assessed a co-payment. However, if the patient is assigned to one of the coinsurance payment levels, the department will assess coinsurance on the claim.

Outpatient Claims - If more than one general outpatient (Ambulatory Procedures Listing) service is performed on the same day, the coinsurance is based on the highest payable procedure code or revenue code on the claim. An individual coinsurance amount is **not** assessed for each procedure code or emergency/observation revenue code for the same date of service.

If a patient receives emergency department or observation services and is then admitted as an inpatient on the same date, department policy allows separate billing of the emergency room charge or observation services on an outpatient claim. Any ancillary services must be shown on the inpatient claim. In these situations, a co-payment or coinsurance is applied to **each** claim.

H-250.3 Per-Claim Adjustments to Payments

H-250.31 Disproportionate Share (DSH)

For inpatient services provided, the department will make adjustments to payments to hospitals that are deemed a disproportionate share hospital in accordance with the statutes and administrative rules governing the time period when the services were rendered.

Federal law requires states to deem a hospital a disproportionate share hospital (DSH) if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean for all hospitals receiving Medicaid payments in the state or if the hospital's low income utilization rate exceeds 25 percent. Reimbursement for DSH is made on a per diem basis.

H-250.32 Medicaid Percentage Adjustment (MPA)

For inpatient services provided, the department will make adjustments to payments to hospitals that are deemed a Medicaid percentage hospital in accordance with the statutes and administrative rules governing the time period when services were rendered.

In accordance with statutes and administrative rules, a hospital is deemed a Medicaid percentage hospital if it meets one of the following criteria:

- The hospital's Medicaid inpatient utilization rate is at least one-half standard deviation above the mean Medicaid utilization rate;
- The hospital's low income utilization rate exceeds 25 per centum;
- Is an Illinois hospital that, on July 1, 1991, had an MIUR that was at least the mean Medicaid inpatient utilization rate and was located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board, and that as of June 30, 1992 was located in a federally designated Health Manpower Shortage Area;
- Is an Illinois hospital that has a Medicaid inpatient utilization rate that is at least the mean Medicaid utilization rate and has a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate;
- Any children's hospital;
- Out-of-state hospitals meeting the federal DSH qualifying criteria.

Reimbursement for MPA is made on a per diem basis.

H-250.33 Medicaid High Volume Adjustment (MHVA)

All hospitals receiving MPA payments, with the exception of hospitals operated by the University of Illinois, the Cook County Bureau of Health Services, and the state-operated psychiatric hospitals receive an additional per diem payment known as the Medicaid High Volume Adjustment Payment. This per diem payment is added to the hospital's inpatient DRG or per diem payments.

H-250.34 Outliers

Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units not reimbursed under the DRG-PPS. These adjustments are determined and paid in accordance with department rules in 89 Ill. Adm. Code 148.130.

Under 89 Ill. Adm. Code 148.130, disproportionate share hospitals that are not reimbursed under the DRG-PPS may be eligible for outlier adjustments for exceptionally costly stays provided to children under the age of six.

Hospitals that do not meet the definition of a disproportionate share hospital may be eligible for outlier adjustments for exceptionally costly stays provided to children under the age of one.

Children's hospitals, as defined in 89 IL Admin. Code section 149.50(c)(A), are eligible to receive outliers on claims for children through the age of 18 effective with admissions on or after January 1, 2008. Children's hospitals, as defined in 89 IL Admin. Code section 149.50(c)(B), are eligible to receive outliers on claims for children through the age of 18 effective with admissions on or after July 1, 2009.

Outlier adjustments are also provided for exceptionally costly or lengthy stays provided by hospitals reimbursed under the DRG-PPS. Outlier adjustments for exceptionally costly or lengthy stays provided by hospitals reimbursed under the DRG-PPS are determined and paid in accordance with department rules in 89 Ill. Adm. Code 149.105.

H-250.4 Quarterly Adjustments to Payments

Quarterly adjustments are identified and reimbursed in accordance with 89 Ill. Adm. Code section 148.

=H-250.5 Outpatient Payment Methodologies

Effective June 15, 2011

The all-inclusive APL rate is considered to cover all services provided by salaried hospital personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment, and all X-ray,

laboratory and therapy provided to the patient on the same day. Exceptions to this are:

- Hospitals are allowed to bill separately on a fee-for-service basis for a salaried physician providing direct patient care. This claim must be billed under the salaried physician's name and NPI (see Topic H-270.21 for additional information):
- Occupational and/or speech therapy services provided in conjunction with physical rehabilitation services may be billed fee-for-service;
- Chemotherapy services provided in conjunction with radiation therapy may be billed fee-for-service.

An outpatient claim must contain at least one procedure code or an emergency department or observation revenue code as listed in the APL. **When any service listed in the APL is performed on a given day, all services provided on that day (excluding the exceptions above) must be billed on a single outpatient institutional claim.**

However, if during the same treatment span, subsequent to emergency department or observation services, the patient is admitted to the hospital as an inpatient, only the emergency room charge **or** the observation service may be billed on the outpatient claim. It is up to the hospital to determine which outpatient service will provide greater reimbursement. Charges incurred as a result of services provided by other outpatient departments prior to the patient's admission, such as laboratory or radiology services, are to be shown on the inpatient claim.

Reimbursement for outpatient services is based upon the rate of the highest-paying procedure code (or emergency department or observation services revenue code) listed on the claim.

H-254 Specialized Requirements for Certain Services

Some services are administered as hospital-covered services but with certain restrictions. Please review the following information for specific guidance.

H-254.1 Transplant Program

The department will cover organ transplants as identified in 89 Illinois Administrative Code 148.82 under Subsection (b) and provided to United States citizens or aliens permanently residing in the United States under color of law pursuant to 42 U.S.C. 1396a(a) and 1396b(v). Such services must be provided by certified organ transplant centers that meet the requirements specified in Subsections (c) through (h) in the above Administrative Code.

H-254.11 Covered Transplant Procedures

Bone marrow, stem cell, pediatric small bowel and liver/small bowel, heart, heart/lung, lung (single or double), liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered provided the hospital is certified by the department to perform the transplant.

H-254.12 Certification Process

To be certified to receive reimbursement for transplants performed on eligible patients, a hospital must complete an application. Inquiries may be forwarded to:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Attention: Transplant Coordinator
607 East Adams, 7th Floor, Springfield, Illinois 62701-2034
1-877-782-5565

The hospital must meet the established certification criteria as described in 89 Ill. Adm. Code, Section 148.82 (d). After the initial certification, the department will conduct an annual review to recertify the transplant center.

H-254.13 Notification of Intent to Transplant

The certified transplant facility must notify the department in writing prior to performance of the transplant procedure. This notification must include the admission diagnosis, the pre-transplant diagnosis, and the initial work-up summary of medical findings. The department will notify the hospital regarding receipt of the notification and provide the appropriate “patient tracking” forms to the hospital.

H-254.14 Reimbursement

Reimbursement will be made pursuant to 89 Illinois Administrative Code 148.82. Payment for inpatient bone marrow transplants includes 50 consecutive inpatient hospital days (including a maximum of seven days prior to transplant for infusion of chemotherapy). Payment for inpatient or outpatient stem cell transplants also includes 50 consecutive days of care.

Solid organ transplants (heart, heart/lung, single lung, double lung, liver, kidney/pancreas, pediatric small bowel and liver/small bowel) must be billed starting with the day of transplant. Inpatient hospital days prior to transplant must be billed on an interim claim. Post-transplant care extending past the allowable days must be billed as an interim claim.

Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center. Payment for kidney and cornea transplants is made at the department's applicable DRG or per diem rate for the hospital. The department does not cover kidney acquisition costs.

Hospital reimbursement for transplants covered under 89 Ill. Adm. Code 148.82 is an all-inclusive rate, regardless of the number of days of care associated with the admission, or, in the case of outpatient stem cell transplants, the number of days of outpatient services. Reimbursement is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for the number of days listed below for specific types of transplant:

1. A maximum of thirty (30) consecutive days of inpatient care for heart, heart/lung, lung (single or double), pancreas or kidney/pancreas transplant;
2. Forty (40) consecutive days of inpatient care for liver transplant;
3. Fifty (50) consecutive days for inpatient bone marrow transplant, and inpatient or outpatient stem cell transplant;
4. Seventy (70) consecutive days of inpatient care for pediatric intestinal (small bowel or liver/small bowel) transplant;
5. For other transplants the number of consecutive days of inpatient care is as specified within the transplant certification process.

Reimbursement will be approved only when the department's letter acknowledging the notification of the proposed transplant procedure and the discharge summary are attached to the hospital's claim.

The department will cover bone marrow searches for bone marrow transplant services. Hospital reimbursement for bone marrow searches is limited to 60 percent of charges up to a maximum of \$25,000. Payment for bone marrow searches will only be made to the certified center requesting reimbursement for the bone marrow transplant. See 89 Ill. Adm. Code, Section 148.82(g)(5).

Outlier/Disproportionate Share:

Applicable outlier payments will be made in accordance with 89 Ill. Adm. Code 148.130.

Applicable disproportionate share payments will be in accordance with 89 Ill. Adm. Code 148.120(g).

H-254.15 Reporting Requirements of Certified Transplant Center

For patient tracking purposes, the center must submit reports and summaries to the department as required in 89 Ill. Adm. Code 148.82 (h). This includes discharge summaries for each patient, statistical information on all transplant patients annually from date of transplant, and other required data.

H-254.2 Services of Physicians Compensated for Direct Patient Care

Hospital salaried physicians, with the cost of their services included in the hospital reimbursement costs, are not approved for participation unless their contractual arrangement with the hospital enables them to submit their own charges for professional services and they do bill private patients and collect and retain payments made.

Teaching physicians who provide direct patient care may submit charges for the services provided, if the compensation paid to them by the hospital or other institution does not include a component for direct patient care. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment.

Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools may be approved for participation in the provision of direct patient services if they maintain a private practice and bill private patients and collect and retain payments made.

Charges are to be submitted only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, this means presence in the operating room performing or supervising the major phases of the operation with full and immediate responsibility for all actions performed as a part of the surgical treatment and personally performing services considered necessary to confirm the diagnosis and findings.

For nonsurgical patients being seen in a hospital or in other medical settings, charges are to be submitted only if the teaching physician is personally responsible for all services provided and is personally involved by having direct contact with the patient.

The patient's medical record must show that these requirements have been met.

H-254.3 Services to Newborn Children

The department requires a separate claim form for the newborn in addition to the claim for the mother; however, reimbursement will be made only on the mother's bill to cover services provided to both the mother and the newborn child. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.

Claims for newborns may be billed to the department under the baby's name and mother's recipient number. These claims will suspend until the baby is enrolled.

If the mother of the baby is not eligible for Medical Assistance but the newborn is, the baby's claim is to be submitted as though the mother were eligible. Once the claim is processed through the system, the hospital will have to initiate an adjustment for those days that were unpaid.

Effective with admissions on and after April 1, 2009, newborn claims that group to DRG 391 regardless of payment method will be paid at zero. If the claims group at a DRG other than 391, the claims will be paid based on the hospital's usual reimbursement methodology.

The Newborn Unit in the Department of Human Services expedites authorization of medical assistance for newborns, and if applicable, initiates the establishment of paternity. The newborn participants promptly receive temporary medical cards and other assistance, if eligible. Refer to Topics H-211.2 and H-211.3 for specific information.

In cases of adoption, the department pays for claims submitted for eligible Medical Assistance participants for pregnancy and obstetrical care. Medical Assistance is always the payer of last resort. If other payment sources are available, Medical Assistance does not pay. If there is a contract or an agreement between an adoption agency, a family or another entity that indicates that it will pay for services related to a birth, that contract is treated as another payment source and the department will not pay.

H-254.4 Inpatient Services to Hospice Patients

All claims for inpatient services rendered to patients enrolled with a hospice must be submitted to the hospice prior to submission of the claim to the department. If the hospice determines that the service was not related to the terminal illness, the hospice denial letter must be attached to the hospital's UB-04 claim form when it is submitted to the department. If the service was related to the terminal illness, the hospice will be responsible for payment of the claim. For information regarding the Hospice Program, refer to the Handbook for Hospice Agencies.

H-254.5 Services Related to Sterilization Procedures

H-254.51 Hysterectomy Performed During Hospital Stay

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 HFS 1977, (Acknowledgment 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.**

Refer to the department's Web site for a facsimile of [Form HFS 1977](#) and the instructions for completion. To ensure that requirements have been met, the physician who obtained the signed Form HFS 1977 must provide the hospital with a copy, which should be reviewed by hospital staff. The UB-04 claim (indicating a hysterectomy was performed) with the HFS 1977 attached can then be sent to the department for processing.

H-254.52 Sterilization Procedures Other Than a Hysterectomy

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

H-254.6 Abortion Services

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

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

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

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

Effective May 16, 2011

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

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

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

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

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

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

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

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

H-256 Home and Community-Based Service Alternatives for Patients Needing Long Term Care

Persons who require long term care in a hospital, nursing facility or Intermediate Care Facility for the Developmentally Disabled may be eligible for home and community-based service (HCBS) alternatives that will enable them to avoid institutionalization. Services that may be available vary, but include homemaker and adult day care.

Illinois has [HCBS waiver programs](#) serving seven distinct populations of persons with chronic care needs. To find out more about these programs, access the Department of Healthcare and Family Services' Web site or call the number listed below. The HCBS waiver programs include:

- 1) Children who are Medically Fragile and Technology Dependent
- 2) Persons with Disabilities
- 3) Persons with Brain Injury
- 4) Persons with HIV/AIDS
- 5) Adults with Developmental Disabilities
- 6) The Elderly
- 7) Persons who may live in Supportive Living Facilities

The department encourages physicians and discharge planners to consider these services as they work to assist patients and their families to plan for long term care. Any questions regarding these programs may be directed to the Bureau of Interagency Coordination at 217-557-1868.

H-260 Payment Process

H-260.1 Charges

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

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

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

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

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

Effective October 1, 2011

- MCO Coverage Beginning During the Inpatient Stay

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

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

- MCO Coverage Ending During the Inpatient Stay

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

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

H-260.2 Claim Preparation and Submittal

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

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

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

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

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

H-260.21 Interim Claims

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

Following are exceptions for which separate claims may be submitted:

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

2. When a patient's category of assistance changes from a federally funded category to the State Family and Children Assistance program, a separate claim is required. The same is true when the patient's category of assistance changes from State Family and Children Assistance to a federally funded category;
3. For interim claims for transplants, see Topic H-254.14.

H-260.22 Zero Balance Bills

The department requires a hospital to submit a bill for any inpatient service provided to an Illinois Medicaid eligible person, including newborns, regardless of payer. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the department's liability on the claim. The department requires that inpatient zero balance bills be submitted subsequent to discharge in the same manner as other bills so that information can be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and also for calculation of disproportionate share and other rates. These provisions apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

H-260.23 Split Bills (MANG - Spenddown)

See Chapter 100, Topic 113 for a full explanation of the spenddown policy. Inpatient and 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 hospital 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 hospital 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.

Hospitals may encounter situations when there are charges associated with a patient for outpatient department services, salaried physician services, and inpatient services, all on the same day. All of these charges may be billed on the inpatient institutional claim. However, hospitals have the option to bill, in addition to the inpatient claim, one outpatient claim containing charges for the use of the emergency room or observation services. All other ancillary services related to the emergency or observation department services are to be shown on the inpatient claim. One salaried physician's services may also be billed under the physician's name and NPI.

If the patient is on a spenddown case, hospitals should follow the guidelines below:

- If the hospital plans to submit an outpatient claim for use of the emergency room, or observation services, in addition to the inpatient claim, then the hospital should clearly identify those applicable charge amounts separately on the billing statement submitted to the FCRC for spenddown calculation.
- If a salaried physician's services are also to be billed, those charges should be clearly identified, with the salaried physician's name on the billing statement submitted to the FCRC for spenddown calculation.

The FCRC determines the order in which bills are applied for the purpose of calculating spenddown. When appropriate, it will issue separate HFS 2432s (Split Billing Transmittals) for multiple services, such as emergency room, observation services, salaried physician services, or inpatient services, rendered on the same day. HFS 2432s will not be issued for bills that are the total responsibility of the patient. When any service is billed for a date that is determined to be a split-bill day, the HFS 2432 must be attached to the claim (see Chapter 100, Topic 113). This form must be attached even if the patient liability amount is zero.

For billing purposes, if emergency department services or observation services are performed and the patient's treatment span crosses midnight, the date of service is still considered the first date. If a spenddown patient's inpatient hospital stay crosses calendar months, the inpatient charges must be separated by month when they are submitted to the FCRC for spenddown calculation. Hospitals must also identify any other insurance payment applicable to services in each calendar month.

For services relating to outpatient series claims, department policy requires that charges for outpatient services be considered by date of service. If a provider submits charges to the FCRC on a patient's behalf, or gives a billing statement to the patient to submit to the caseworker, the statement must show charges for each date of service. The provider should not lump charges for multiple days of service into one total sum.

As an example, if a facility submits a series bill with 13 treatment dates in a calendar month, the dates of service must be identified and the charges identified for each date of service on the billing statement. The spenddown will be considered met on the day when the medical charges incurred equal or exceed the patient's spenddown.

Providers who submit charges improperly will have their statements returned by the FCRC with a request to break down the charges by service date.

Any questions regarding calculation of spenddown should be directed to the FCRC serving the patient. For information on the FCRCs, please refer to the [DHS Web site](#). The DHS Office Locator can be found by scrolling to the bottom of the DHS Web page.

H-260.3 Payment

Payment made by the department for allowable services will be at the lesser of either the department's calculated payment, or the provider's covered charges. This policy excludes hospice providers, government-owned or operated hospitals, and children's hospitals as defined in 89 Illinois Administrative Code Section 149.50 (c)(3)(A).

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, Topic 114.

All claims adjudicated by the department will be identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the hospital's payee address on file with the department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the department and General Appendix 7 for explanations of Remittance Advice detail.

H-260.4 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 the deductible and coinsurance amounts due on bills on which Medicare benefits are paid. **If Medicare benefits are denied as not being medically necessary, the department will not make payment.**

When a hospital has billed Medicare for services provided to patients whom the department has identified as being Medicare-eligible, but the hospital has received documentation from the Medicare intermediary showing that the patient was not Medicare-eligible, the hospital must attach a copy of the Medicare documentation to the UB-04 claim form and submit it to the department. Acceptable documentation includes a copy of a properly completed Form SSA 1600, (Request for Claim Number Verification), signed and dated by a Social Security representative; a copy of the Medicare Explanation of Benefits (EOB/Remittance Notice) showing no coverage at the time the service was rendered; or a copy of a letter from the Social Security Administration indicating ineligibility. The document submitted must establish ineligibility at the time services were provided.

Additional information regarding policy and claim preparation for hospital Medicare crossover claims can be found in Appendix H-2e.

When a patient chooses to use a Medicare HMO in lieu of Medicare, there will be no deductible or co-insurance to bill the department. The Medicare HMO payment is considered payment in full. However, for patients who are covered under both Medicaid and a Medicare HMO, the department allows hospitals to submit inpatient claims to identify the inpatient days associated with those patients. The department will pay these claims at zero, but the inpatient days will be included in the hospital's disproportionate share calculation. Specific billing instructions for these claims are shown in Appendix H-2e.

Hospitals billing for the professional component of outpatient services should refer to the Handbook for Physician Services for billing instructions.

H-260.41 Inpatient Medicare/Medicaid Combination Claims

- **Inpatient Claim - Part A and Part B Benefits**

Subsequent to adjudication by Medicare, inpatient Medicare/Medicaid combination claims must be submitted to the department on a single institutional claim form. Charges are to be the hospital's usual and customary charges for the services billed; however, the amount of payment will not be based on those charges. The department calculates its payment based upon the appropriate reimbursement methodology. The department's reimbursement will never exceed the deductible for coinsurance due.

Allowable charges will be accumulated by the department for the hospital for review in establishing prospective payment rates.

When the patient's eligibility is not continuous, deductible amounts may only be submitted if the patient was eligible on the day on which the deductible was due (the deductible is due on the first day of the inpatient stay). If the patient was not eligible on the day the deductible was due, the provider still has to show the appropriate value code for the deductible with a zero dollar amount. Additionally, coinsurance/lifetime reserve amounts may only be submitted for the days for which the patient was eligible. When applicable, the coinsurance/lifetime reserve to be considered by the department would be calculated by multiplying the number of covered days on the claim for which coinsurance/lifetime reserve is due by the daily coinsurance/lifetime reserve amount as designated by Medicare.

- **Inpatient Claim - Part A Benefits Only**

Subsequent to adjudication by Medicare, the UB-04 or the equivalent electronic format is to be submitted to the department, completed in accordance with instructions in Appendix H-2e and the UB-04 Data Specifications Manual. All coinsurance days and lifetime reserve days must be utilized, if applicable.

- **Inpatient Claim - Part B Benefits Only**

For participants who have exhausted their Part A Benefits or have Medicare Part B coverage only, the total payment received from the Medicare intermediary for technical services covered by Medicare Part B benefits is to be shown as a credit on the inpatient claim.

Payment will be made by the department on charges submitted based on the appropriate reimbursement methodology less the Medicare B payment and any other third party credits shown. For cost-reporting purposes, this type of stay is to be logged as Medicaid days.

- **Inpatient Claim - Part A Exhausted, Partial Medicare Coverage During a Hospitalization and Services Disallowed under Medicare Part A**

Charges for inpatient services provided to patients that are not reimbursable under Medicare Part A benefits will be adjudicated by the department when the charges are incurred under the following circumstances:

1. Services are denied for payment only because the patient's Hospital Insurance Benefits, **including lifetime reserve days**, are exhausted.
2. Charges for inpatient services rendered to a participant whose Medicare Part A benefits began or exhausted **during** his inpatient stay are to be submitted in accordance with instructions in Appendix H-2e.
3. Services that are allowable under Title XIX - Medical Assistance but disallowed under Title XVIII - Medicare Part A.

When certain services provided during the stay are covered under Medicare Part B benefits, the total payment received from the Medicare intermediary for technical services covered by Medicare Part B benefits is to be shown as a credit on the inpatient billing.

In situations where Part A has exhausted, the claim must be billed using the appropriate occurrence code denoting benefits exhausted, along with the date Part A benefits were exhausted. The occurrence code must be utilized as described in the UB-04 Data Specifications Manual.

Payment will be made by the department on charges submitted based on the rate effective for the hospital on the date of service less the Medicare Part B payment and any other third party credits shown. For cost-reporting purposes, this type of stay is to be logged as Medicaid days.

Professional component for either inpatient or outpatient lab or X-rays may be billed on the CMS 1500 to the Part B Carrier.

H-260.42 Outpatient Medicare/Medicaid Combination Claims

- **Outpatient Claim – Part B Benefits**

Claims for ambulatory services provided to patients who are eligible for Medicare Part B Benefits must be submitted to the hospital's intermediary for adjudication prior to submittal to the department for payment consideration of the department's liability for the deductible and coinsurance amounts.

Medicare-covered services are not subject to fee-for-service reimbursement. Therefore, regardless of the type of procedure performed, the charges (excluding physician professional component charges) are to be submitted in accordance with instructions in the UB-04 Data Specifications Manual. Payment is made up to a maximum of the deductible and coinsurance amounts due as provided in Chapter 100.

The department multiplies the reimbursement rate by the total departments visited during the billing period to arrive at the department allowable amount. For this purpose, a department is defined as a revenue code category. For example, Revenue Code Category 027X, comprised of Revenue Codes 0270 through 0279, would be considered one department.

If the total number of department's visited is not indicated with the appropriate value code, the calculation will be made using one department. The Medicare payment is subtracted from this figure and the result is compared to the maximum deductible/coinsurance the hospital is seeking from the department. Reimbursement will be made at the lesser of these two amounts.

For "take home" drugs that are not covered by the Medicare Program, charges for the pharmacy department may be submitted to the department for a patient according to the specifications of the Pharmacy Program.

- **Outpatient Psychiatric Claim - Part B Benefits**

After the department receives billing and Medicare adjudication information concerning ambulatory psychiatric services, payment is made up to a maximum of any deductible and coinsurance amounts due as provided in Chapter 100, Topic 112.5.

Drugs dispensed for treatment and/or diagnostic purposes to patients receiving ambulatory psychiatric services during the ambulatory visit are considered to be included in the approved per visit rate and no separate charge may be made.

- **Outpatient Physical Rehabilitation Claim – Part B Benefits**

After the department receives billing and Medicare adjudication information concerning outpatient physical rehabilitation services, payment is made up to a maximum of any deductible and coinsurance amounts due as provided in Chapter 100, Topic 112.5.

Charges for Medicare-covered appliances, prostheses and "take home" medical equipment and supplies provided patients who are eligible for Medicare Part B benefits will be "crossed over" electronically by the Illinois Part B carrier. (Refer to Chapter 100, Topic 112.5.) To receive payment by the department, the hospital must be enrolled as a Medical Equipment/Supplies provider, Categories of Service 41 and 48.

Additional charges for services provided with the outpatient rehab service that are not covered by the Medicare Program will not be given consideration by the department.

- **Outpatient Renal Dialysis Claim – Part B Benefits**

After the department receives billing and Medicare adjudication information concerning renal dialysis services, payment is made on any deductible and coinsurance amounts due as provided in Chapter 100.

H-260.43 Hospital-Owned Ambulance Services for Participants with Medicare Part B

Charges approved by Medicare are exempt from the department's fee-for-service payment policies, as they relate to ambulance services provided as ambulatory hospital services. The hospital is to submit a claim for payment consideration of deductible and coinsurance amounts in the same manner that Medicare crossover claims are submitted to the department for any other hospital service.

All services provided on a given day in conjunction with ambulance services must be billed on a single institutional claim using the hospital's NPI.

Transportation charges disallowed by Medicare, which are covered by the department, are billable under fee-for-service using Form HFS 2209 (Transportation Invoice). Please refer to the Handbook for Providers of Transportation Services.

H-260.5 Fee Schedule

A listing of allowable outpatient procedure codes is available on the department's Web site. 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 Comprehensive Health Services
607 East Adams
Springfield, Illinois 62701

H-260.6 Post Billing of Ancillary and Room and Board Charges

If a facility determines that an error was made in reporting the usual and customary charge for an ancillary service(s) and/or room and board accommodation(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 a Remittance Advice (see Chapter 100, General Appendix 7 for an explanation of the information reported on the paper 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."

H-260.7 Payment Adjustments

General policy and procedures regarding payment adjustments are provided in Chapter 100, Topic 132. Chapter 100, General Appendix 6 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 claim or to correct erroneous ancillary services or room and board charges. Completed adjustment forms should be mailed to the following address at the department for processing:

Illinois Department of Healthcare and Family Services
Hospital Adjustment Unit
P.O. Box 19128
Springfield, Illinois 62794-9101

H-260.71 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.

H-260.8 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.

To ensure that the department properly and timely recovers improper payments or excess payments related to patient credit balance, the department recommends that all providers implement a credit balance report with the following data elements to monitor quarterly (March 31, June 30, September 30, and December 31):

Recipient Name (Last Name, First Name)
Medicaid Number (RIN)
Dates of Service (From [Beginning date of service] & To [Ending date of Service])
Voucher Number
Document Control Number
Amount of Credit Balance (Overpayment)
Amount Repaid
Method of Payment (Check or recovery from future payments)
Reason for Credit Balance

Additional data elements may be added to this list to enable each provider to manage credit balances on a claim-by-claim basis.

This report will strengthen internal controls related to credit balances and provide a mechanism for monitoring these credit balances. The department recommends that this information be maintained by the provider and made available for review and audit.

If a patient has a credit balance at the end of a quarter, the provider must do one of the following:

- Submit HFS 2249 adjustment forms that identify each specific service being adjusted, and request that the amount be credited against future billings; or
- Submit HFS 2249 adjustment forms that identify each specific service being adjusted, and submit a check, made payable to the Illinois Department of Healthcare and Family Services, in the amount of the total overpayment; or
- Submit a check, made payable to the Illinois Department of Healthcare and Family Services, in the amount of the total overpayment, with supporting documentation of the specific claim(s) being adjusted. The department will initiate the adjustment.

Credit balances as a result of Third Party payers, i.e., health insurance, Medicare, Personal Injury, Workers Compensation, or private pay, should be submitted to:

Bureau of Collections
Third Party Liability
P.O. Box 19140
Springfield, IL 62794-9995

Credit balances as a result of any other reason, i.e., incorrect billing, duplicate payment, void for re-bill, etc., should be submitted to:

Bureau of Comprehensive Health Services
Hospital Adjustment Unit
P.O. Box 19128
Springfield, IL 62793-9128

H-260.9 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, Topic 112.3.

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, Topic 130.5 for further details.

H-262 Inpatient Services

General inpatient hospital services are defined by the department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the department has established specific participation requirements. Included in general inpatient services are medical, surgical, pediatric, orthopedic, maternity, intensive care services, etc. Inpatient services provided to a patient during an acute stage of renal disease are also considered to be general inpatient services.

Inpatient services are covered when a patient's medical necessity for services on an inpatient basis are documented (see Topic H-202, Record Requirements). If surgery is performed, the provider must indicate the attending physician and the operating surgeon identification numbers on the institutional claim form. Reimbursement will not be made for services that were billed as acute inpatient care and subsequently denied in the review process as not being medically necessary (see Topic H-266, Utilization Review.)

A hospital's reimbursement for an inpatient stay is all-inclusive. If the hospital finds it necessary to transport a patient to another facility for additional tests or specialized services, the inpatient hospital is responsible for payment to the other facility. The hospital should identify the ancillary services performed at the other facility and show the charges on the inpatient claim billed to the department. The other facility may not bill the department separately for the ancillary services performed at its location.

The day on which a patient begins a leave of absence must be treated as the day of discharge or non-certified day and cannot be counted as a covered day unless the patient returns to the hospital prior to midnight of the same day.

The total number of days for which charges can be made cannot exceed the number approved by the appropriate utilization review authority.

H-262.1 Per Diem Reimbursed Care

Charges for inpatient per diem reimbursed care are to be the hospital's usual and customary charges. Payment shall be made based upon calendar days. The day of discharge is not counted. An admission with discharge on the same day is counted as one day. If a patient is admitted, discharged and re-admitted on the same day, only one day is counted.

H-262.2 DRG-Reimbursed Care

Charges for DRG-reimbursed inpatient care should be the facility's usual and customary charges. The assignment of a discharge to a DRG will, as appropriate, be based on the patient's age, sex, principal diagnosis, secondary diagnoses, procedures performed, and discharge status. The department utilizes the CMS Medicare DRG Grouper, with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

H-262.3 Tuberculosis Treatment

Inpatient services necessary for the treatment of tuberculosis are considered to be general inpatient services. However, the department can make payment for such services only when they are provided to a person who is a resident of a county or a jurisdiction that does not levy a special tax for the purpose of providing care for tuberculosis patients. It is the responsibility of the hospital to determine whether such tax levy funds are available to pay for these services prior to submitting a claim to the department. If the tax levy funds are exhausted or only cover certain items, it is the responsibility of the hospital to obtain an official notice from the county and attach it to the UB-04 when it is submitted to the department.

=H-262.4 Psychiatric Services

Effective January 2013

Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder. Except as specified below, inpatient services for psychiatric care and treatment are not considered to be general inpatient services and may be provided only by hospitals enrolled for Category of Service 21, Inpatient Hospital Services (Psychiatric).

All inpatient psychiatric services billed as Category of Service 21 are exempt from DRG reimbursement and will be reimbursed at a per diem rate.

Inpatient psychiatric services may be provided by a general hospital **or** by a psychiatric hospital enrolled with the department for Category of Service 21. Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, inpatient psychiatric services provided by psychiatric hospitals are covered services only for patients ages 65 and over and patients under age 21, or up to age 22 for those receiving these services immediately prior to attaining age 21.

A general care hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service (Category of Service 20) only on an emergency basis for a maximum period of three (3) days. During this period, the hospital must seek placement of the patient in a hospital enrolled to provide psychiatric services. Such services are subject to review by the department or its designated agent.

The department will not reimburse for psychiatric admissions for Department of Children and Family Services (DCFS) wards without a written consent from the DCFS Consent Unit or the Child Intake and Recovery Unit. The DCFS Consent Unit and the Child Intake and Recovery Unit (CIRU) are the only entities authorized to consent for psychiatric admissions of DCFS wards. The DCFS consent form must be placed in the patient's file to document that consent to admit the DCFS ward for inpatient psychiatric services was authorized. A faxed copy of the consent form is acceptable.

The DCFS Consent Unit may be reached during normal business hours, 8:30 a.m. - 4:30 p.m., Monday through Friday at 1-800-828-2179. The Consent Unit fax number is 312-814-7015. The Child Intake and Recovery Unit (CIRU) may be reached after regular business hours, on weekends and holidays at 866-503-0184.

Inpatient psychiatric services are not covered services for adult participants of the Family and Children Assistance program cases in the City of Chicago. Only children eighteen (18) years of age or younger on these cases are covered. Persons nineteen (19) years and older covered under the Family and Child Assistance program are not eligible.

H-262.5 Physical Rehabilitation Services

Physical rehabilitation inpatient services provided to patients during an acute stage of a disabling illness or injury are considered to be general inpatient services. When the acute stage ends and the patient no longer requires acute hospital care but does require comprehensive inpatient physical rehabilitation services, such services may be provided only by hospitals enrolled for Category of Service 22, Inpatient Hospital Services (Physical Rehabilitation).

Payment for inpatient physical rehabilitation services will be made only when provided by a general hospital or a rehabilitation hospital, enrolled with the department for Category of Service 22. **All physical rehabilitation services are exempt from DRG reimbursement and will be reimbursed at a per diem rate.**

The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to a patient with a major disability for the purpose of habilitating or restoring that person to a realistic maximum level of functioning.

Inpatient physical rehabilitation services are not covered for adult participants of the Family and Children Assistance program cases in the City of Chicago. Only children eighteen (18) years of age or younger on these cases are covered. Persons nineteen (19) years and older covered under the Family and Child Assistance program are not eligible.

=H-262.6 Provider-Preventable Conditions

Effective July 1, 2012

Revised January 2013 Retroactive to July 1, 2012

Provider-preventable conditions are those conditions or events that are considered reasonably preventable through compliance with evidence-based guidelines. The department edits inpatient claims for two categories of PPCs. This policy applies to all hospitals, all inpatient claims (including Medicare/Medicaid combination claims), and both the DRG and per diem reimbursement methodologies:

1. PPCs defined as Hospital-Acquired Conditions (HACs): Beginning May 1, 2008, hospitals were required, for informational purposes only, to code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. The POA indicator will identify if the condition was introduced after the inpatient admission. Effective with admissions on and after July 1, 2012, the department will reduce each inpatient claim by \$900.00 if a designated HAC presented during the inpatient admission. The department's designated list of diagnosis codes or diagnosis/procedure code combinations to be utilized as [HACs](#) is on the HFS Medicaid Reimbursement Web page.
2. PPCs defined as Other Provider Preventable Conditions (OPPCs): The department will deny payment for claims relating to a wrong surgical procedure performed on a patient; a surgical procedure performed on the wrong patient; or a surgical procedure performed on the wrong body part. Hospitals must submit claims to report these incidents and are instructed to populate the inpatient claims with the following specific supplementary diagnosis codes as appropriate:
 - E876.5 – Performance of wrong operation (procedure) on correct patient
 - E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
 - E876.7 – Performance of correct operation (procedure) on wrong side/body part

The above designated E codes may be reported in FL 72; however, they must also be identified in FL 67A-Q.

=H-262.61 Present on Admission Indicator Reporting*Effective July 1, 2012**Revised January 2013 Retroactive to July 1, 2012*

Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department services, observation, or outpatient surgery, are considered as present on admission.

The department requires hospitals to submit a POA indicator for the principal diagnosis code and every secondary diagnosis code on inpatient hospital claims. This requirement applies to all inpatient services and all hospitals.

For specific coding information refer to the UB-04 Data Specifications Manual or 837I Implementation Guide.

The POA data element on an electronic claim (837I) must be in Loop 2300.

H-266 Utilization Review

The department contracts with HealthSystems of Illinois (HSI), a designated quality improvement organization (QIO), to perform inpatient and outpatient hospital review services under the fee-for-service delivery system to assess medical necessity, length of stay, the accuracy of coding and Diagnosis Related Group assignments, and quality of care provided to persons covered by medical assistance. Designated quality improvement organization means an organization designated by the department that is experienced in utilization review and quality assurance, which meets the guidelines in Section 1152 of the Social Security Act and 42 CFR Part 475.

HSI's contact information is listed below:

Business Address - HealthSystems of Illinois, 2050-10 Finley Road, Lombard, Illinois 60148

Business Telephone - Monday – Friday 8:30 a.m. – 5:00 p.m. 630-317-5100

Business Fax - 24 hours, 7 days per week, 630-317-5101

Certification Numbers and Assistance:

Toll-Free Voice Line, Monday – Saturday 7:00 a.m. – 5:00 p.m., 1-800-418-4033

Toll-Free Fax Line, 24 hours, 7 days per week, 1-800-418-4039

Help Line, Monday – Friday 8:30 a.m. – 5:00 p.m., 1-800-418-4045

Information follows regarding review criteria, utilization review requirements, types of reviews, and hospital utilization control. Additional specific review process information, reconsideration timeframes, and provider notification forms are detailed in the HSI Utilization Review Manual. This manual is available on the [HSI Web site](#) under the Hospital Education Resources link.

H-266.1 Types of Criteria

InterQual Criteria

HSI will utilize the most current version of InterQual Criteria to determine the medical necessity of inpatient hospital admissions and continued stay for patients presenting with medical/surgical diagnoses, as well as psychiatric and detoxification diagnoses.

The InterQual Criteria is usually released during the second quarter each year. Prior to implementing new versions of the InterQual Criteria, HSI will send a Provider Update bulletin to all hospital Medicaid liaisons advising them of the implementation date of the new criteria. This Provider Update bulletin will also be posted on HSI's Web site.

Screening criteria may be ordered by contacting:

McKesson HealthSolutions
275 Grove Street, Suite 1-110
Newton, MA 02466
Phone: 1-800-522-6780 or 617-273-2800
Fax: 617-273-3777
[E-mail](#)

H-266.2 Utilization Review Requirements

The department, or its designated quality improvement organization, may conduct preadmission, concurrent, prepayment, and/or postpayment reviews to determine the following:

- Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;
- The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges;
- Through DRG validation, the validity of the diagnostic and procedural information supplied by the hospital;
- The completeness, adequacy and quality of hospital care provided;
- Whether the quality of the services meets professionally recognized standards of healthcare;
- Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient healthcare facility of a different type.
- The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of 42 CFR 412.82 and 412.84.

H-266.3 Types of Reviews

HealthSystems of Illinois conducts Certification of Admission/Concurrent/Continued Stay Review on the diagnosis codes noted in Attachments A, B and C and Retrospective Prepayment Review for DRG codes in Attachment D. These [diagnosis and DRG codes subject to review](#) are periodically revised, and are posted on the department's Web site as well as HSI's Web site. The department shall provide hospitals with a notice 30 days before a service is subject to utilization review. However, the department will not send a notice to hospitals when the ICD-9-CM coding guidelines mandate a coding change requiring a 4th or 5th digit code extension on codes currently subject to review. These code extensions will automatically be subject to review.

HealthSystems of Illinois does not conduct review of claims where Medicare Part A is the primary insurance. Claims that identify other primary insurance plans are subject to review.

The Children's Mental Health Screening, Assessment and Support Services (SASS) program requires that all inpatient psychiatric admissions for the target population must be screened. Additional information on the SASS Program is in Topic H-268 and in the [Handbook](#) for Providers of Screening, Assessment, and Support Services, on the department's Web site.

H-266.31 Concurrent Review

Concurrent review consists of a certification of admission and, if applicable, a continued stay review.

Effective March 1, 2007, all admitting diagnosis codes identified on [Attachments A, B, and C](#) became subject to mandatory concurrent review. The department allowed a 90-day transition period for hospitals to comply.

The certification of admission is performed to determine the medical necessity of admission and to assign an initial length of stay based on the criteria for the admission. The review process is initiated when the hospital or attending physician submits a request for certification via telephone or via HSI's Web-based system. Requests should be submitted at the time of admission or within 24 hours of admission. However, a request may be submitted at any point during hospitalization.

Hospitals may request an admission/concurrent review for stays of three (3) or fewer days **after discharge has occurred** only if the requests are:

- Submitted via HSI's Web-based review system, and
- Submitted within seven (7) days of discharge.

The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed on an inpatient stay. A request for certification of continued stay should be requested by the hospital or attending physician to ensure that certification is obtained prior to the end of the current certified period. To facilitate this process, the QIO provides the hospital liaison with a report that lists certifications that expire within one (1) day. The hospital must record the Actual Admit and Discharge Date (if applicable) for each patient on the list and fax the list to the QIO.

Hospitals will be allowed the opportunity to submit a concurrent review request for hospitalizations after 30 days of the participant's discharge, as long as the admission has been certified by HSI. The request must be submitted to and approved by HSI and any claim for payment must be received by the department within the department's claim submission timeframe; i.e., no later than 12 months from the "Through" date of the service on the claim.

The department will allow limited exceptions to mandatory concurrent review, and permit those claims to suspend for retrospective prepayment review. Claims that relate to an exception must be submitted with a cover memo that identifies the exception. The hospital must send these claims to the hospital's assigned billing consultant at the department for manual review. After the department reviews the exception, the claim will suspend for retrospective prepayment review.

The department will allow limited exceptions in the following circumstances:

- A participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment at the time of admission.
- The patient remains unresponsive or has a physical or mental impairment during the hospitalization that prevents the hospital from identifying coverage under one of the department's medical programs.
- Other – the hospital must provide narrative description.

H-266.32 Prepayment Review

The department may require hospitals to submit claims to the department for prepayment review and approval prior to rendering payment for services provided. The QIO will provide at least 48 hours notice prior to the scheduled review for Hospitals designated for onsite review. Hospitals designated for offsite review will be given fourteen (14) days to submit copied charts by mail.

H-266.33 Postpayment Review

Postpayment review may be conducted on a random sample of stays following reimbursement to the hospital for the care provided. The department may also conduct postpayment review on specific types of care. Cases selected for postpayment review and not meeting medical necessity for admission or continued stay will be referred to the Office of Inspector General (OIG).

H-266.4 Hospital Utilization Control

Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare and follow the utilization review requirements as set forth in 42 CFR Part 456. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must also meet the utilization review plan requirements in 42 CFR, Part 456. Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50 (c) (1) shall be in accordance with federal regulations.

H-268 Children’s Mental Health Screening, Assessment, and Support Services (SASS) Program

Public Act 93-0495 requires the Illinois Department of Healthcare and Family Services to establish a prescreening system for children and adolescents experiencing a mental health crisis who are presenting for an inpatient psychiatric admission.

The department implemented the Children’s Mental Health Screening, Assessment and Support Services (SASS) program July 1, 2004. There are three target populations for the SASS program: (1) all children and adolescents under the age of 21 for whom DCFS is legally responsible; (2) children under the age of 18 for whom DHS has been requested to pay for their hospitalization; and (3) children and adolescents under the age of 21 enrolled in HFS’s Medical Programs including All Kids.

Effective July 1, 2004, all inpatient psychiatric admissions for the three target populations must be screened through the SASS program. The department identifies the [diagnosis codes subject to utilization review](#) on the department’s Web site. **If the admitting diagnosis code for a child or adolescent appears on Attachment A or Attachment B, the hospital must contact the Crisis and Referral Entry Service (CARES) at 1-800-345-9049, TTY 1-800-905-9645, prior to admitting the child or adolescent.** This program does not change the consent process for children and adolescents for whom DCFS is legally responsible.

CARES will enter a prior approval into the department’s system to document the assignment of the case to a SASS provider. At the same time, CARES will make an entry into the department’s quality improvement organization, HealthSystems of Illinois’ (HSI’s) system documenting that the hospital called. For those situations requiring an emergency response, the SASS provider must arrive onsite within 90 minutes of receiving the referral from CARES to perform a mental health screening and assessment of the child or adolescent. For non-emergency situations, the SASS provider must arrive within 24 hours to perform the screening and assessment. If the SASS provider has not responded within that time period, hospitals should contact CARES again.

The decision as to whether or not the child or adolescent is hospitalized remains with the attending physician. However, reimbursement for the admission is contingent on the hospital cooperating with the SASS program.

A general care hospital not enrolled for Category of Service 21 (inpatient psychiatric services) may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of three (3) days. **An admission to a general care hospital for psychiatric care will also be subject to the prior authorization requirements of the SASS program.**

Each SASS provider is responsible for coverage of a specific geographical area, referred to as a Local Area Network (LAN). SASS providers are encouraged to contact the hospitals in their LANS to determine if there are any administrative requirements that must be completed in order for the SASS provider to participate in the child or adolescent's treatment and discharge planning.

Utilization Review – Coordination of Care

Hospitals will continue to call HSI to initiate the utilization review process. To enhance coordination of care for psychiatric admissions for children and adolescents, the hospital shall involve the SASS provider in the child or adolescent's treatment plan during the inpatient stay and in the development of the child or adolescent's discharge plan in order to facilitate linkage to appropriate aftercare resources. The SASS provider will be responsible for documenting their involvement with an admission and with discharge planning by entering information into HSI's Web-based system. If the hospital has requested access to HSI's Web-based system, the hospital staff will be able to verify that the required SASS information has been entered by accessing a Web-based report. If the hospital finds that the SASS information has not been entered, they should contact the SASS provider directly. HSI will perform a review of the inpatient hospital stay only after documentation has been recorded in HSI's Web-based system that CARES was contacted or SASS involvement occurred.

Concurrent review is required for all psychiatric admissions for children and adolescents that extend beyond a single day.

Reimbursement

If the hospital fails to contact CARES for a SASS screening prior to admission, but during the hospitalization SASS becomes involved, reimbursement will be made beginning with the day of SASS involvement, if HSI determines the continued stay is medically necessary.

If the outcome of the SASS screening is a recommendation that in lieu of hospitalization the child or adolescent receive care through community services, but the attending physician believes that an admission is medically necessary, the appropriateness of continued stay will be determined through the utilization review process. The first day of an admission is covered as long as a CARES or SASS entry has been recorded on HSI's system. To initiate a subsequent review, HSI should be contacted on the second day of the child or adolescent's psychiatric admission. All coordination of care requirements, including involvement of SASS providers in discharge planning, must be met in order to receive reimbursement. Both CARES and the SASS provider will make an entry documenting admission screening involvement and the SASS provider will make an entry documenting discharge planning involvement into HSI's data system. This information will then be transmitted to the department.

Application for Assistance

Children and adolescents enrolled in the SASS program who are not enrolled in one of the medical assistance programs administered by Healthcare and Family Services **must**, by law (59 Ill. Admin. Code 131.30), apply for medical assistance.

Effective with claims received on and after March 15, 2006, services provided after the first day of SASS enrollment to children and adolescents who do not meet this application requirement will not be reimbursed, except as noted below. Hospital providers may ensure reimbursement for services provided after the first day of enrollment under the SASS program, by assisting these children and their families in applying for medical assistance.

If a child has been hospitalized as part of the SASS intervention, it is the hospital's responsibility to assist and ensure that an application has been filed prior to the end of the hospitalization. If a hospital is not already enrolled as an [All Kids Application Agent \(AKAA\)](#), information is on the department's Web site.

Exception: In those instances where a family is unable, or refuses, to apply for medical assistance, or the hospital finds it impossible to assist the family in applying, the hospital provider may request an exception of the eligibility requirement by contacting the DHS Children and Adolescent Services unit. Hospitals should inform families that if they refuse to file an application, and an exception is not granted, the hospital can bill the family for the hospitalization. By filing a complete application, regardless of the application outcome, the family will not be financially responsible for the hospital stay.

Hospitals may request an exception by calling 773-794-4875. The following information will be required at the time the exception request is made: (1) the hospital's name and HFS provider ID number; (2) the child's name, date of birth, recipient identification number (RIN); (3) the date of initial service; (4) the reason for exception and; (5) a hospital contact person and telephone number. DHS will notify the hospital by telephone on the outcome of the review within one (1) calendar day of the request being made. In addition, the hospital will receive written notification of the review outcome within ten (10) calendar days.

Processing of claims: If the inpatient stay is a one-day stay, and the admission date is the only date billed, the claim will go through normal processing. All other claims received on and after March 15, 2006, by HFS for services rendered to DHS-funded children will be reported to the hospital provider on a remittance advice as "Suspended for Department Review." Once DHS determines that a complete application has been submitted for the child, or an exception has been granted by DHS, HFS will be notified to release the claim for processing. Providers will receive a subsequent remittance advice reporting the final disposition of the claim.

If no application is filed, and no exception is granted, the claim will be rejected with an error code A77 – No Medicaid Application Was Filed. However, hospitals may rebill and be reimbursed for the admission date only. Any other inpatient days in that stay must be shown as non-covered and any associated charges must be shown as non-covered.

Reimbursement rates: If a complete application is received by DHS or HFS, or an exception to the eligibility application is granted by DHS, the inpatient services will qualify for Disproportionate Share Hospital Adjustment Payments [DSH], Medicaid High Volume Adjustment Payments [MHVA], and Medicaid Percentage Adjustment Payments [MPA] for which the hospital qualifies.

The policies addressed apply to out-of-state hospitals only if they are located in counties contiguous to Illinois. Any questions regarding the exception process may be directed to the DHS Children and Adolescent Services unit at 773-794-4875.

Additional information is contained in the [Handbook](#) for Providers of Screening, Assessment, and Support Services, available on the department's Web site.

=H-270 Ambulatory Services

Effective June 15, 2011

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 Ill. Admin. Code section 140.461(a), and Ambulatory Surgical Treatment Centers (ASTCs).

Emergency, observation and referred services are to be provided in an ambulatory setting. Ambulatory services are reimbursed by the department at the appropriate rate in the appropriate manner for the setting in which the care is given, i.e., fee-for-service or all-inclusive rate (for Ambulatory Procedures Listing services).

Unless a service is on the Ambulatory Procedures Listing (APL), all services currently provided in the hospital outpatient setting are subject to the fee-for-service payment methodology. This means that for these services, hospitals will be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services will be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting; no separate facility fee will be paid. The appropriate handbook for the type of service provided should be referenced for billing of these services.

NOTE - Institutional Medicare crossover claims are excluded from the fee-for-service billing methodology. 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. The claim should be submitted according to Medicaid billing requirements.

H-270.1 Ambulatory Procedures Listing (APL)

Certain procedures provided in the outpatient hospital or ambulatory setting 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 Web site. The procedures are grouped and subgrouped as follows:

Group 1 - Surgical Groups

- a) Surgical Group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment.
- b) Surgical Group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency department treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment.
- c) Surgical Group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency department and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons.
- d) Surgical Group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency department, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. Certain dental procedures performed by dentists are included in this group. However, a patient must meet the following criteria in order for dental procedures to be performed in the outpatient setting:
 - 1) Requires general anesthesia or conscious sedation;
 - 2) Has a medical condition that places the patient at an increased surgical risk, such as, but not limited to: cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or
 - 3) Patient cannot safely be managed in an office setting because of a behavioral, developmental or mental disorder.

Group 2 - Diagnostic and Therapeutic Groups

- a) Diagnostic and Therapeutic Group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician.
- b) Diagnostic and Therapeutic Group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study.

- c) Diagnostic and Therapeutic Group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician.
- d) Diagnostic and Therapeutic Group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures.

Group 3 - Emergency Department Services

Group 3, Emergency Department Services, consists of two levels for emergencies, which are Emergency Level I and Emergency Level II, and one Non-Emergency/Screening as described in the following topics. Each of the three levels will be paid at the rate assigned to that level of service.

Group 4 - Observation Services

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.

Group 5 - Psychiatric Services

A group for psychiatric services is established to reimburse for certain outpatient psychiatric services when provided by a hospital that is enrolled by the department to provide inpatient psychiatric services.

Group 6 - Rehabilitation Services

A group for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services that are provided by a hospital that is enrolled with the department to provide inpatient physical rehabilitation services.

H-270.2 Emergency Department Services

Emergency Department services can be either emergency or non-emergency services. The initial service must be provided at the hospital in its Emergency Department and must be directed or coordinated by the Emergency Department physician.

The words “emergency services” mean those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The determination of the level of service reimbursable by the department shall be based on circumstances at the time of initial examination, not upon the final determination of the patient’s actual condition, unless the actual condition is more severe. The initial examination is defined as taking the history and physical as documented in the emergency department’s medical record and ordering appropriate test(s) and ancillary service(s) that support or rule out the suspected condition.

Hospitals certified to provide a Department of Children and Family Services (DCFS) screening examination in the emergency room must use a Source of Admission 8 on the institutional claim form or Loop ID 2300, CL102, if billing electronically, plus an appropriate HCPCS/CPT procedure code to identify this type of service.

If a patient enrolled with one of the state-contracted Managed Care Organizations (MCO) receives out-of-network emergency services, the MCO will pay the hospital at the department’s rate. The MCO will pay based upon whether the services provided were emergency, urgent care, or screening services. The definition of emergency services as found in the Balanced Budget Act of 1997 also includes inpatient hospital services needed until a patient is stabilized. The MCO is responsible for payment of any applicable inpatient emergency services at the department rate.

H-270.21 Salaried Physicians Providing Services in an Outpatient Department (Excluding Emergency Level 3 Screening)

A claim may be submitted for one salaried physician involved in direct patient care in **any** outpatient setting, in conjunction with an APL procedure(s). This policy excludes billing for a salaried pathologist, radiologist, nurse practitioner, or certified registered nurse anesthetist (CRNA).

For this purpose only, salaried physician is defined as a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide Emergency Department care.

The fee-for-service (FFS) claim for a salaried outpatient department physician service will be subject to the following requirements:

- For each patient, a professional claim may be submitted under the practitioner's name and NPI for a visit or procedure for only one salaried physician's services in an outpatient department. The hospital may also bill on the institutional claim format for the APL procedure for that patient for that date of service.
- If more than one salaried physician provides services to the same patient, the services provided by additional salaried physicians are considered part of the all-inclusive APL rate and cannot be billed as FFS.

H-270.22 Emergency Level I

Emergency Level I services are defined as emergency services provided in the hospital's Emergency Department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function, or services that require an intense level of physician or nursing intervention. An "intense level" is defined as more than two hours of documented one-on-one nursing care or interactive treatment.

Examples of Emergency Level I care **may** include, but are not limited to:

- Anaphylactic allergic reaction
- Severe respiratory distress
- Seizures of unknown origin or new onset
- Gross gastrointestinal hemorrhage
- Acute chest pain of suspected cardiovascular or pulmonary origin
- Acute cerebral vascular accident (stroke)
- Laceration involving major blood vessels
- Septic shock

Emergency Level I services may be billed on the institutional claim format for the facility services and the HFS 2360 for the salaried physician services as described above.

H-270.23 Emergency Level II

Emergency Level II refers to "Emergency Services" that do not meet the above definition of Emergency Level I care, but which are provided in the hospital Emergency Department for a medical condition manifesting itself by acute symptoms of sufficient severity that urgent or unscheduled care is required.

Examples of Emergency Level II care **may** include, but are not limited to:

- Lacerations which require repair with sutures, staples or bonding materials (NOT steri strips)
- Dehydration
- Minor blunt head injury without loss of consciousness
- Asthma
- Otitis

- Pharyngitis
- Administration of parenteral narcotics

Emergency Level II services may be billed on the institutional claim format for the facility services and the HFS 2360 for the salaried physician services as described above.

H-270.24 Non-Emergency/Screening Level

Non-Emergency/Screening Level refers to those services provided in the hospital Emergency Department that do not meet the requirements of Emergency Levels I or II stated above. For such care, the department will reimburse the hospital **either** applicable current FFS rates for the services provided (services billed on the professional claim format) **or** a screening fee (billed on the institutional claim format), but not both.

Examples of Non-Emergency/Screening Level care **may** include, but are not limited to:

- Simple laceration that did not require repair
- Minor sunburn
- Suture removal

The hospital is allowed to select the most appropriate billing mechanism on a patient-by-patient basis to bill for Non-Emergency/Screening services provided in the hospital's Emergency Department. No more than one of the options may be billed for any one calendar day.

H-270.3 Observation Services

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.**

There are three (3) levels of observation billing, based upon the number of hours that the patient is actually in observation. All observation services are billed using Revenue Code 0762, and the number of hours in observation is indicated in Service Units. **The department will not reimburse for observation services of less than one hour.** The levels are as follows:

Observation Time Period	Units Billed
1 hour through 6 hours, 30 minutes	1 through 6
6 hours, 31 minutes through 12 hours, 30 minutes	7 through 12
12 hours, 31 minutes or more	13 or more

The hospital may bill for both observation and other APL procedures, but will be reimbursed only for the service with the highest rate of payment. Observation services must be billed using one of the CPT codes identified in the [APL](#) Group Order document on the Web site.

H-270.4 Psychiatric Clinic Services

The two categories of ambulatory psychiatric services for which the department provides payment to appropriately enrolled hospitals are: Psychiatric Clinic Services, Type A (COS 27) and Psychiatric Clinic Services, Type B (COS 28). See Topic H-201.26 for specific enrollment information for these categories.

Except for children eighteen (18) years of age or younger in Family and Children Assistance cases in the city of Chicago, psychiatric services are not covered services for participants of Family and Children Assistance (Category 07).

For patients of categories of assistance other than Category 07, ambulatory psychiatric services may be provided by a hospital that is enrolled to provide the appropriate type of ambulatory psychiatric service.

Reimbursement is in accordance with procedures provided in the Ambulatory Procedures Listing (APL). Psychiatric clinic Type A and B services must be billed using one of the specified procedure codes identified in the [APL](#) Group Order document on the Web site.

=H-270.41 Type A Services

Effective June 15, 2011

The department defines Type A ambulatory psychiatric services as an ambulatory service package consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling.

Services are reimbursed at the all-inclusive rate approved by the department. This rate is considered by the department to include services provided by salaried hospital personnel (except as noted in this section), all drugs administered and/or provided for home use and all equipment, drugs and supplies used for diagnostic and/or treatment purposes during the ambulatory visit.

H-270.42 Type B Services

Type B ambulatory psychiatric services are defined by the department as an active treatment program in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four (4) hours per day at a minimum of three (3) half days of active treatment per week. The duration of an individual patient's participation in the Ambulatory Psychiatric Services, Type B, treatment program is limited to six (6) months in any twelve (12) month period.

When Type B services have been provided, the reimbursement is made at the all-inclusive rate approved by the department. This rate is considered by the department to include services provided by salaried professional and ancillary personnel (except as noted in this section) and any expenses incurred for supplies and materials, etc., in the provision of the services.

=H-270.5 Physical Rehabilitation Services

Revised June 15, 2011

Except for children eighteen (18) years of age or younger in Family and Children Assistance cases in the City of Chicago, ambulatory physical rehabilitation services are not covered services for participants enrolled in the Family and Children Assistance (Category 07) program.

Ambulatory services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an ambulatory basis.

Reimbursement for ambulatory physical rehabilitation procedures in the Ambulatory Procedures Listing (APL) is based on the all-inclusive rate in effect on the date of service.

The all-inclusive rate is considered by the department to cover services provided by salaried hospital personnel (except the services of a salaried physician involved with direct patient care, as noted under Topic 270.21), all drugs administered and/or provided for take home use, all equipment and supplies used for diagnostic and/or treatment purposes, and all X-ray, laboratory, and therapy services (except occupational and/or speech therapy; see Definitions, Page vi) provided to a patient on the same day as the ambulatory visit.

Unless medical supplies and equipment, braces and prosthetic devices are provided in conjunction with an APL service, prior approval may be needed. See the Handbook for Providers of Medical Equipment and Supplies for further information.

H-270.6 Series Claims

Certain outpatient services provided on multiple dates of service can be submitted on one institutional claim form. Submission of ambulatory series claims must be in accordance with the UB-04 Data Specifications Manual. A series claim must contain an appropriate series revenue code (shown in Appendix H-3) and series-billable procedure code from the Ambulatory Procedures Listing. **All** services rendered to the patient on series-billable days are to be shown on the same claim.

Renal dialysis claims may also be submitted as series bills. Refer to Appendix H-2 for billing instructions.

Series bills may be submitted for up to a maximum of thirty-one (31) days from the date of the first visit. If the series is longer than thirty-one (31) days, the claim must be split. **Claims for patients in the State Chronic Renal Disease Program cannot cross calendar months.**

Series claims cannot contain multiple APL groups. The claim must be split in order for the services to be reimbursed.

The date range for a series claim must encompass the beginning and ending service dates for the time period being billed. Do **not** automatically bill from the first day of the month through the last day of the month if a service was not provided on those days.

When rates are changed, series bills must be split on the date the rates are changed. If the claim is not split, it will be paid at the incorrect rate for a portion of the series.

Hospitals may, but are not required, to split series ambulatory claims around an inpatient stay. Ambulatory claims that are not split must identify the inpatient days as non-covered.

H-270.7 Expensive Drugs and Devices

A hospital or ambulatory surgical treatment center (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 Web site.

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

The reimbursement level for the **procedure** will remain at the amount assigned to the highest payable APL procedure.

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 a drug or device requires prior approval, requests must be submitted on Form HFS 1409, Prior Approval Request, and include an explanation of the medical necessity. The [HFS 1409](#) and instructions are available on the department's Web site.

The provider will receive written notification of the department's decision. The provider must render the approved service, or the first treatment in a series of approved treatments, within thirty (30) 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.

H-275 Ambulatory End Stage Renal Disease Treatment (Category of Service 25)

Ambulatory ESRD treatment services are defined by the department as renal dialysis treatments and those other ambulatory services that are directly associated with the dialysis treatments provided to persons who are chronic renal patients. These services may be provided by an outpatient renal dialysis department of the hospital, a satellite unit of the hospital, or a free-standing chronic dialysis center certified by Medicare.

Renal dialysis claims may be submitted utilizing any valid revenue code; however, one valid renal dialysis code must be present to allow for reimbursement. The department utilizes the distinct per visit Medicare composite rate for dialysis reimbursement. The department will calculate reimbursement at the Medicare approved all-inclusive rate or covered charges, whichever is less.

The rate is all-inclusive except for those professional services provided by the physician. The all-inclusive rate covers dialysis, equipment, supplies, and routine dialysis monitoring tests (i.e., hematocrit and clotting time) used by the facility to monitor the patients' fluids incident to each dialysis treatment.

If an outside lab performs the included tests, the lab has to bill the facility and the facility is responsible for payment. The facility's composite rate includes these services, and the department will make no additional reimbursement for these routine tests.

Non-routine laboratory tests may not be billed by the facility. An independent laboratory enrolled with the department must bill the department to receive reimbursement.

The department allows an add-on payment for certain injectable drugs billed on outpatient renal dialysis claims. The covered injectable drug codes are identified in the [Renal Dialysis Injectable Drugs listing](#) on the department's Web site. The Physician Fee Schedule, also on the department's Web site, identifies the current rates. The allowable add-on payment will be at the lesser of the department's rate, or the provider's covered charges. No additional payment will be made for the administration or dispensing of these drugs.

The provider must report these drugs on the institutional claim format in conjunction with Revenue Code 0636, utilizing HCPCS codes and National Drug Codes (NDCs) to reflect the type of drug being administered. The provider must bill by units. If multiple drugs are shown on the claim, Revenue Code 0636 must be reflected for each drug provided during the service period. See Appendix H-2 for specific billing instructions.

The department continues to reimburse Erythropoietin billed under Revenue Codes 0634 or 0635 with Value Code 68. Providers must use the appropriate HCPCS code and corresponding NDCs.

General policy and procedure for bill preparation, submittal, and payment is provided in Chapter 100, Topics 112 and 130. Additional specific billing policy and procedure pertinent to ambulatory end-stage renal dialysis treatment services is contained in Appendix H-2.

H-275.1 Services Provided to Participants with Medicare Part B

Claims for ambulatory end-stage renal dialysis treatment services provided to patients who are eligible for Medicare Part B benefits are to be submitted on the institutional claim format to the provider's carrier as indicated in Appendix H-2e.

After the department receives billing and adjudication information on claims submitted to the Medicare Part B carrier, payment is made on any deductible and coinsurance amounts due as provided in Chapter 100, Topic 112.5.

H-275.2 Services Provided in a Patient's Home

Charges for Continuous Cycling Peritoneal Dialysis (CCPD) or Continuous Ambulatory Peritoneal Dialysis (CAPD) services provided in a patient's home, under the direction and supervision of the dialysis center staff, are to be made at the same single unit charge approved by Medicare for services provided in certified dialysis facilities. Reimbursement will be pro-rated at 3/7 of the single unit charge to allow for daily billing.

The dialysis center is responsible for the teaching program, for professional and technical assistance and for providing and maintaining all necessary equipment and supplies, without additional charge

The facility may not charge for any plumbing, electrical or other modifications required in a patient's home to enable the provision of dialysis services in the home. Dialysis center staff is to advise the local DHS office of any necessary modifications so that arrangements can be made by that office for the work to be done.

H-275.3 State Chronic Renal Disease Program

The Illinois State Chronic Renal Disease Program assists Illinois residents who have been diagnosed as having chronic renal disease at the state of irreversible renal impairment requiring a regular course of dialysis to maintain life. The program is for patients with chronic renal diseases who require lifesaving care and treatment, but do not qualify for Medicaid, All Kids, or Veteran's Care, or cannot meet spenddown. The program is the payer of last resource after Medicare and private insurance, if applicable.

The patient must have a documented need for dialysis and treatment has to be provided by a Medicare certified facility. This program covers the dialysis treatment only. No injectable drugs are covered under the program.

Patients must meet income qualifications and be a U. S. citizen or meet certain immigration requirements. Factors that also affect eligibility include earned income, family size, payments made for other insurance (including Medicare), other medical expenses, transportation costs and necessary employment expenses. The services provided under the program are available at little or no cost, depending on how the patient qualifies. In some cases the patient may be required to pay a participant fee, if their family income exceeds the standard.

[Applications](#) are available at the Medicare approved dialysis facility where the dialysis services are provided, or may be downloaded from the department's Web site. The social workers at the facilities assist the patient in completing the application package. The social worker submits the application package to the department, where a financial evaluation is completed. A determination is made as to what the patient's participation fee to the facility, if any, will be. The department notifies the social workers of their approved patients. Patients are approved for no more than a twelve (12)-month period and need to reapply prior to the end of the approval period.

State Renal Program claims are billed according to institutional claim guidelines. Appendix H-2 contains billing instructions for renal dialysis claims.

To obtain additional information, please contact the State Chronic Renal Disease Program Coordinator in the Bureau of Comprehensive Health Services at 217-524-7143.

H-278 Sexual Assault Survivors Treatment Program

Under the Illinois Sexual Assault Survivors Emergency Treatment Act, the department reimburses certified Illinois transfer centers or treatment hospitals and other providers for outpatient services to alleged sexual assault survivors who are not covered by private insurance and are not eligible under one of the department's applicable medical programs. The services are provided to victims of alleged sexual assault at no charge to the victims or their families.

Hospitals may register sexual assault survivors in an online registry system. This process will allow survivors to receive follow-up care from any community provider of their choice for ninety (90) days following the initial hospital visit. Using this process, other providers such as physicians, physician assistants, advanced practice nurses, pharmacies, laboratories, and hospitals providing follow-up care will bill the department directly. **If the sexual assault survivor is not registered, the hospital where the initial examination was performed will continue to be responsible for all follow-up care.**

The registration will be entered during the initial emergency room visit using the department's Medical Electronic Data Interchange (MEDI) System. General information regarding how to use the [MEDI](#) system can be found on the department's Web site.

This registration system does not change the billing procedures for the initial hospital sexual assault emergency room visit. Hospitals will still be responsible for submitting all provider bills associated with this initial emergency room visit. Hospitals will continue to use the Illinois Sexual Assault Program Outpatient Hospital Billing Form to submit these charges. This billing form may be obtained from the Program Coordinator of the Sexual Assault Survivor Program by calling 217-782-3303.

Hospitals will register a sexual assault survivor into the Sexual Assault Survivor Registration Site (ERSASS). In order to use the ERSASS, the hospital employee must complete the MEDI registration process, and the hospital's account administrator for MEDI must authorize the employee to have access to ERSASS. When ERSASS access has been granted, the employee will follow these steps:

- Log into the MEDI system
- Select the MEDI link
- Select the ERSASS link under "Authorized Applications"
- Select Create Registration on the left, then "Register" to begin the registration process. Enter the survivor's name, date of birth, Social Security number (if available), and the date of hospital service.

Using this information, MEDI will check to see if the sexual assault survivor is eligible under one of the department's applicable medical programs. If the survivor is found to be Medicaid eligible, a message will immediately appear that the hospital should bill the department's Medical Assistance Program. If the survivor is not Medicaid eligible, a message will appear indicating that the survivor has been successfully registered in the MEDI system.

The Sexual Assault Survivor Registration, when accessed through the MEDI System, will produce an Authorization Voucher, HFS 3870, and an instruction sheet. This voucher will allow the patient to receive follow-up services related to their sexual assault from any community provider of their choice for ninety (90) days following the initial hospital visit. Under the program, a non-enrolled HFS provider may render services. In addition, a checklist will be generated for hospital use only that identifies the file as part of the Illinois Sexual Assault Program.

The Authorization Voucher and instruction sheet should be given to the survivor before leaving the hospital. The voucher has a unique number assigned to the survivor and also contains the survivor's name, the hospital's name and the date of the initial emergency room visit. The voucher is valid for a period of ninety (90) days from the date of the initial emergency room visit. The department cannot reimburse outside providers directly if a voucher has not been issued.

The sexual assault evidence kits are provided by the Illinois State Police at no charge to the hospitals and may be obtained by calling 1-800-356-7311.

For information regarding certification of hospitals as Sexual Assault Transfer Centers and Sexual Assault Treatment Centers, contact:

Office of Health Care Regulations
Illinois Department of Public Health
525 West Jefferson, 5th Floor
Springfield, IL 62761
Telephone: 217-782-7412

Questions regarding the MEDI Sexual Assault Survivor Registration process or the Sexual Assault Survivor Program may be directed to:

Attn: Program Coordinator
Sexual Assault Survivor Program
Healthcare and Family services
P.O. Box 19129
Springfield, Illinois 62794-9129
Telephone: 217-782-3303

H-279 Subacute Alcohol and Substance Abuse Treatment

Subacute alcoholism and other drug abuse treatment is a covered service for participants under Title XIX (Medical Assistance) and All Kids and for children ages 13 through 18 in Family and Children Assistance cases in the City of Chicago. It is not a covered service for Family and Children Assistance (Category 07) cases ages 19 or over in the City of Chicago or persons in an 07 case of any age in downstate Illinois.

Subacute alcohol and substance abuse drug-free treatment services are to be provided in a subacute setting licensed by the Department of Human Services (DHS) or a hospital licensed by the Department of Public Health. A facility must be certified for participation by DHS and enrolled by the Department of Healthcare and Family Services as a Medicaid provider. Services will be provided by or under the direction of a qualified treatment professional in accordance with a treatment plan approved by a physician. A qualified treatment professional must meet minimum requirements set by DHS.

Treatment services are funded through the Department of Human Services, and claims are billed electronically to DHS utilizing DARTS (Department's Automated Reporting and Tracking System). The Department of Healthcare and Family Services edits the claims received through the Department of Human Services and creates Remittance Advices that are then sent to the providers.

Subacute alcoholism and other drug abuse treatment services do not require prepayment review. However, services are subject to post-payment audit.

Covered treatment services include outpatient, residential, detoxification, and psychiatric evaluation services. Certain services are subject to benefit limitations. However, all services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process will be provided to individuals under age 21 as a Healthy Kids (EPSDT) benefit and without regard for the established benefit limits for alcohol and substance abuse services.

Benefit limits will not be applied to a woman who enters treatment during pregnancy and through the end of the month in which the sixty (60)-day period following termination of the pregnancy ends (post partum period), or until services are no longer clinically necessary, whichever comes first. This benefit does not apply to a woman who enters treatment services after delivery.

The amount approved for payment for alcoholism and other drug abuse treatment is based on the type and amount of services required by and actually delivered to a patient. The amount is determined in accordance with prospective rates developed by the Department of Human Services' Division of Addiction Services Administration (DASA) and approved and adopted by the Department of Healthcare and Family Services (see 77 Ill. Adm. Code, Section 2090.70). The adopted rate shall not exceed the charges to non-Medical Assistance patients.

The [DASA Medical Benefits, All Kids, and Family Care Policy Manual](#) is available on the DHS Web site, or a paper copy is available by contacting the following:

Illinois Department of Human Services
Division of Addiction Services Administration
Attention: Medicaid Liaison
Harris Building, Harris II
100 South Grand Avenue East, Second Floor
Springfield, Illinois 62762

Questions may be referred to the [DASA Helpdesk](#).