



School Based/Linked Health Center Services Provider Handbook

**Illinois Department of Healthcare and Family Services
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Foreword

The Department of Healthcare and Family Services (HFS) or “Department” is the agency that administers Illinois’ Medical Assistance (Medicaid) Program, as well as other public healthcare programs. This handbook, along with recent [provider notices](#) and the [Handbook for Providers of Medical Services, General Policy and Procedures](#), will act as an effective guide to participation in the [Department’s Medical Programs](#). It is important that both the provider of services and the provider’s billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department’s Medical Programs policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes and are posted on the [Provider Handbooks](#) webpage. The Department encourages providers to utilize the [Provider Handbook Supplement](#) for guidance in claim submittal.

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

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

Providers submitting X12 electronic transactions must refer to the [Handbook for Electronic Processing](#). This handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

Inquiries regarding coverage of a service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 877-782-5565.

201 **Provider Enrollment**

School Based/Linked Health Centers (SBLHC) must be certified by the Illinois Department of Public Health (IDPH) and meet the standards established in [77 Ill. Adm. Code, Part 2200](#). IDPH will assign an initial certification date. Certification will be reviewed by IDPH every two years.

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201.1 Enrollment Requirements

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

201.2 Enrollment Approval

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

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

201.3 Enrollment Denial

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

201.4 Provider File Maintenance

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

201.5 Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be

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used by the provider in the preparation of claims; any inaccuracies found must be corrected by submitting a modification in IMPACT.

Provider change information must be updated via the on-line application available on the Illinois [Medicaid Program Advanced Cloud Technology \(IMPACT\)](#) Provider Enrollment web page. The on-line modification function is available to notify the Department of updates to required enrollment information. Failure of a provider to properly update the IMPACT provider enrollment system with corrections or changes may cause an interruption in participation and payments.

201.6 Department Responsibility

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

202 Provider Reimbursement

202.1 Charges

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

202.2 Claim Preparation and Submittal

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

202.2.1 Paper Claim Submittal

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

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

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

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

If envelopes are unavailable, claims can be mailed to:

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

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

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

202.2.2 Electronic Claim Submittal

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

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

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202.3 Payment

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

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

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

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

202.4 Fee Schedule

The [fee schedule](#) of allowable procedure codes and special billing information is available on the Department's website.

203 Covered Services

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

Listed below are reimbursable services when provided in a SBLHC setting:

- Basic medical services;
- EPSDT;
- Reproductive health;
- Mental health;
- Substance abuse;
- Dental; The Department contracts with DentaQuest of Illinois to manage the dental program.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook. For further information refer to [77 Ill. Adm. Code Section 2200.60](#). For allowable procedure codes, refer to the [SBLHC Fee Schedule](#).

204 Non-Covered Services

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

In addition, certain services provided by the center are not reimbursable by the Department to the SBLHC. The services include but are not limited to:

- The Division of Mental Health (DMH) or the Division of Alcoholism and Substance Abuse (DASA) Services. When the center determines these services are required, a referral may be made to the appropriate resource. Refer to the Handbook for Providers of Healthy Kids Services for the policy and procedures for the referral, as well as a list of referral resources.
- Any medical services not listed on the Practitioner fee schedule or the [SBLHC fee schedule](#) must be referred to the Managed Care Organization (MCO), a primary care provider or other appropriate source of medical care.
- Services provided off-site (not at the SBLHC site) cannot be submitted for reimbursement using the SBLHC's provider name and the provider number assigned by the Department.

205 Record Requirements

Record requirements for medical transportation services are provided in [89 Ill. Adm. Code 140.494](#). Refer to the [General Policy and Procedures](#) Handbook for information regarding the maintenance of records and the retention of records.

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

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

206 General Limitations and Considerations of Covered Medical Diagnostic and Treatment Services

Medical services are covered in SBLHC only when provided in accordance with the [Handbook for Practitioners Rendering Medical Services \(pdf\)](#).

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It is the center's responsibility to assure that all necessary treatment and follow-up is coordinated with the patient's Care Coordination plan.

206.1 Protocol

The protocol is a written instrument which defines the relationship between the physician and other health care professionals at the center and identifies the medical services to be provided within the scope of each practitioner's expertise. The annual review must be written, maintained on file at the center and be available upon request by Department staff. Health care professionals are defined as a resident physician, advanced practice nurse (APN), physician assistant (PA) and registered nurse.

The Protocol on file must meet the following guidelines:

- The written document reasonably describes the kind of services to be provided and, as appropriate, criteria for referral and consultation with the physician.
- The document must specify which authorized procedures do not require a physician's presence as the procedures are being performed.
- The document must specify arrangements for communication with a physician for services that are outside of the established protocol.

Further information can be found at [68 Ill. Adm. Code Section 1300.410](#) and [68 Ill. Adm. code Section 1350](#).

Services submitted for payment to the Department that are provided by a resident physician or a registered nurse must have the supervising physician's, APN's, or PA's counter signature documented in the medical record.

206.2 Maternity Care

To provide prenatal and postpartum care at the center, the center must comply with [77 Ill. Adm. Code Section 2200.70](#). For complete maternity care policies and billing procedures, refer to the [Handbook for Practitioners Rendering Medical Services \(pdf\)](#).

207 Pharmacy Services

The center may bill for injectable drugs and birth control devices only when they have been purchased by the center.

207.1 Prior Approval for Oral and Injectable Drugs

Prior approval authorization is required for certain drugs covered by the Department's Medical Programs.

207.2 Prior Approval Procedure: To request prior approval, the center should complete a Request for Drug Prior Approval, [Form HFS 3082 \(pdf\)](#). The completed [HFS 3082](#) must be faxed to the Drug Prior Approval Unit at (217) 524-7264 or (217) 524-0404. The center must provide the National Drug Code (NDC) and the State License Number of the administering practitioner at the time of the request. Whether a prior approval request is approved or denied, the participant will receive notification of the outcome of the request.

208 Medical Diagnostic and Treatment Services

208.1 Laboratory Tests

Only those laboratory tests and examinations which are essential for diagnosis, evaluation and treatment are covered. Batteries of “rule out” tests are not covered. The appropriate CPT or HCPCS Code is to be used when billing for laboratory tests. The Department has a maximum dollar amount payable for certain panels and chemistries. Refer to the [SBLHC fee schedule](#).

The center may charge only for those tests performed at the center using the center’s staff, equipment and supplies. When the patient presents for laboratory tests only, an office visit charge may not be made.

Centers providing laboratory services must be in compliance with the [Clinical Laboratory Improvements Amendment \(CLIA\) Act](#). The center may not charge for laboratory tests performed by any outside laboratory. Charges are not to be made when a specimen is obtained by center staff and sent out of the office.

Exception: When a specimen is obtained by the center and sent to the Illinois Department of Public Health for lead screening, the provider may bill for the drawing fee. Refer to the fee schedule for the appropriate procedure code and modifier.