Billing Webinar for
Certified Local Health Departments
November 17, 2016

Presented by: The Illinois Department of Healthcare & Family Services
in collaboration with the Illinois Association of Public Health Administrators
Vaccines For Children Program Changes

- Please refer to the September 19, 2016 provider notice at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160919a.aspx
- Effective October 1, 2016, vaccines obtained through the Vaccines For Children (VFC) program are limited to children age birth through 18 who have Title XIX (19) eligibility on the date of service.
- Children with Title XXI (21) - also referred to as CHIP - and State-Funded eligibility must receive private stock vaccines.

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<th>Title XIX (19)</th>
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- The Non-Institutional Providers (NIPs) webpage at https://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx has been updated with a variety of resources regarding the VFC program changes, including previous webinar presentations, MEDI example slides and registration instructions, vaccine billing instructions, pediatric vaccine reimbursement rates effective 10/01/16, and the vaccination Q &A.
Vaccines For Children Program Changes – Eligibility Verification

- Providers must verify eligibility on each date of service or risk non-payment or reduced payment.

- Providers may verify participant eligibility and obtain Title and State-funded information using:
  - HFS MEDI system
  - 270/271 - Health Care Eligibility Benefit Inquiry and Response transaction, instructions for which may be found at [https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx](https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx)

- Providers using an outside vendor should contact that entity in order to determine where and how the Title and State-funded information will be presented.

- Title and State-funded information is **not** available through the Automated Voice Response system (phone eligibility system).

- In the rare instances MEDI is unavailable, providers may contact 1-800-842-1461 and bypass the AVRS to speak to an operator. **Please note:** the option to bypass the automated eligibility verification system and speak to an operator to obtain Title information is **only** available when MEDI is down.
Vaccines For Children Program Changes – Eligibility Verification (cont’d)

MEDI Eligibility Verification

- Review Case Type, Special Information, and Managed Care Enrollment and/or Third Party Liability if applicable
- “Special Information” will provide Title or State-funded eligibility information
- Example MEDI screen shots may be found in the VFC 9/19/16 Webinar Slides available on the NIPs webpage

270/271 Eligibility Verification

- HIPAA Eligibility Request – 270
- HIPAA Eligibility Response – 271
- Requires ASC X12 format software
- For instructions, please refer to https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx
Vaccines For Children Program Changes – Billing & Reimbursement

- There is no change to billing and reimbursement for VFC stock administered to Title XIX (19) participants
- Providers must privately purchase vaccines for children with Title XXI (21) and State-Funded eligibility and seek reimbursement from HFS, or the HFS Managed Care Organization as applicable
- Bill the vaccine-specific procedure code
- Reimbursement rates are published in the Practitioner Fee Schedule at https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/Pages/default.aspx
- For vaccines available through VFC for Title XIX (19) eligible children, HFS will continue to reimburse the practice expense of obtaining the vaccine through VFC at the lesser of the provider charge amount or the rate shown in the Unit Price column of the Practitioner Fee Schedule
- For private stock vaccines administered to Title XXI (21) and State-Funded eligible children, HFS will reimburse fee-for-service at the lesser of the provider charge amount or the rate shown in the State Max column of the Practitioner Fee Schedule
- Reimbursement for the practice expense of administering injections is included in the office visit when the participant sees a practitioner. If the participant is seen solely for the injection, the CPT code for a minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician (99211) may be submitted to cover the injection service expense.
Vaccines For Children Program Changes – 317 Funded Stock

- Please refer to the October 14, 2016 provider notice at [https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn161014c.aspx](https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn161014c.aspx)

- To ensure access to vaccines for Title XXI (21) and State-Funded eligible children the Illinois Department of Public Health is providing the opportunity to order vaccines (317-funded vaccines) through November 26, 2016 or as long as funding is available

- Billing instructions for vaccines obtained from 317 funded stock:
  - Providers must charge HFS $6.40 for each vaccine-specific procedure code for vaccines obtained through the 317 fund supply
  - Reimbursement will be at the “Unit Price” rate found on the Practitioner Fee Schedule

- For Participants enrolled in one of the Medicaid Managed Care Organizations, providers should contact the individual plan for billing policies and procedures as well as reimbursement information
Hepatitis C Treatment

- Please refer to the September 30, 2016 provider notice at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160930b.aspx

- Effective with dates of service on/after October 1, 2016, the cost of newer, direct-acting antivirals (DAAs) for the treatment of Hepatitis C will be covered for participants in earlier stages of the condition (META VIR score of F3)

- Hepatitis C drugs require prior authorization to be eligible for reimbursement. Additional information such as the criteria and the necessary prior authorization request forms can be found on the HFS Criteria and Forms webpage
Screening, Treatment, Medical Monitoring, Counseling and Preventative Drugs for Persons at Risk of Exposure to HIV

- Please refer to the September 26, 2016 Informational Notice at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160926a.aspx

- Pursuant to Public Act 99-0772, and upon federal approval, HFS shall provide coverage for all drugs approved by the FDA, and recommended by the federal Public Health Service or the U.S. Centers of Disease Control and Prevention, for pre-exposure and related pre-exposure prophylaxis services.

- HFS currently covers services for persons at high risk of exposure to HIV, including Truvada, which is currently approved for prevention of pre-exposure without a prescription or prior approval.

- Illinois law and the Illinois AIDS Confidentiality Act (which changed in 2008) permit “opt-out” HIV testing as recommended by the CDC.

- Pre-test counseling is not required. Instead the information may be provided:
  - Verbally
  - In writing
  - By video or other electronic means

- Informed consent is not mandated but can be obtained verbally, in writing, or through general consent to medical treatment with a provision allowing an opt-out to HIV testing.
IMPACT
Enhancement to Allow For The Entering Of A Remittance Address

- Please refer to the provider notice dated October 28, 2015 at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151028a.aspx

- Beginning December 12, 2015 the Enrollment system was modified allowing enrollment of Typical or Atypical Sole Proprietor, Group, Facility/Agency/Organization(FAO) or Atypical Agency with multiple NPI’s (National Provider Identifiers) to enter an optional address termed the Remittance Address.

- If a Remittance Address was not entered, then the provider’s payments and remittance advices were directed to the Pay to Address listed for that TIN.

- It is also important to note that there was only be one Remittance Address per IMPACT enrollment no matter the number of locations listed in that enrollment.

- In summary, the IMPACT Remittance Advice modification allowed providers using one TIN, but having multiple NPI’s, to have their own address for the routing of payments and remittance advices.

- Providers had previously been informed that the Pay To Address in IMPACT would be used to update all Legacy Payees with the same TIN; however, this did not happen until after January 1, 2016.
A provider notice dated May 13, 2016 was issued reminding providers to select *ALL* correct Specialty/Subspecialty combinations upon completion of the initial application or revalidation in the IMPACT system dated May 13, 2016 and can be found at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513a.aspx

It is important to make the correct selection in order to be reimbursed for all categories of services currently provided to Medicaid participants.

Claims that are submitted with information that is different from the most recent provider information sheet may be delayed in processing or rejected.

Separate applications have been completed by providers for each Specialty/Subspecialty causing the system to generate additional Provider ID numbers resulting in rejections of claims because the system does not recognize them.

Review of the table of IMPACT Provider Types, Specialties and Subspecialties is a good reference guide on the IMPACT website which provides important information for providers who may have questions regarding these issues.
IMPACT
Provider Enrollment Data Exchange & Claims Processing

- Please refer to the May 13, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513b.aspx regarding the transfer of data from the IMPACT enrollment system into the system that processes provider claims known as the Legacy Medicaid Management Information System (MMIS)

- Provider information sheets are mailed to providers at the office address on file and to all “payee address” if different from the office address

- Providers are responsible for reviewing all information for accuracy or risk a delay in claim processing or rejections. Any needed corrections must be made in IMPACT.

- **Please note:** receipt of the provider information sheet is the provider’s confirmation that information submitted in IMPACT - whether a new enrollment or an update to a previous enrollment – has been moved to the Legacy MMIS. The provider information sheet, if correct, serves as notification to the provider that the department is ready to process claims against the new or updated information submitted through IMPACT.

- It is critical for payment of claims that the provider name matches the “Doing Business As” name in IMPACT. Do not change the historical provider name submitted on claims to match the “Doing Business As” name in IMPACT until you have received the provider information sheet from HFS.
Please review the Provider Notice issued July 11, 2016 at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160711a.aspx

Once the revalidation process has been completed, new rendering/servicing providers will be required to enroll in IMPACT whom have not been previously required to enroll as a provider with Illinois Medicaid.

The Department will notify providers when these types of rendering/servicing providers need to begin the enrollment process via a provider notice posted on the IMPACT website.

For additional information on the IMPACT system including frequently asked questions, webinars and other training guides visit the IMPACT website.

If you have additional questions or need assistance, please contact the IMPACT Help Desk:
- By email: IMPACT.Help@Illinois.gov
- By phone: (877) 782-5565, option 1
Postpartum Visits and Perinatal Care Transitions

- Please refer to the Informational Notice dated September 29, 2015 at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150929a.aspx

- Care transition is the movement of patients from one health care practitioner or setting to another as their condition and care needs change, ensuring coordination and continuity of care.

- The postpartum visit should be scheduled or confirmed prior to hospital discharge and discharge instructions should include the appointment date, time and location.

- The postpartum visit allows for a physical exam, supportive guidance on healthy behaviors, assessment of health conditions, including depression, preconception counseling, and reproductive life planning, including discussion/initiation of birth control, if not previously initiated.

- Reimbursement is allowed for one comprehensive postpartum visit with additional visits for related issues outside the routine postpartum visit payable if supported with appropriate coding/documentation.

- The postpartum provider should ensure that women are linked back to their primary care provider (PCP) after the postpartum visit which is especially important if the patient has other medical conditions, complications during pregnancy, or pre-existing co-morbidities.

- If the PCP is unknown please review the a “Quick Reference Tool” link provided as an attachment to the Provider Notice in identifying the patient’s PCP.
Prior Approval for Children’s Therapy Services

- Please refer to the October 23, 2015 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151023b.aspx

- As a result of Public Act 098-0651(pdf), the Department is required to prior approve all adult and child therapy services for medical necessity. HFS implemented prior approval for medical necessity of physical and occupational therapy for children through age 20 effective with dates of service on or after November 16, 2015.

- Please note that children between the ages of 0 and 3 may be eligible to receive therapy services through the Illinois Early Intervention Program, which provides resources and supports to children with diagnosed disabilities or developmental delays. Families should first make application to the Early Intervention Program through the Department of Human Services (DHS) for these services before submission of a prior authorization request to HFS.

- Home health providers must submit the following information for each prior approval:
  - HFS 1409 (pdf) Prior Approval Request Form
  - Practitioner Order
  - Therapist Initial Evaluation
  - HCFA 485 Plan of Care

- Outpatient therapy providers must submit the following information for each prior approval:
  - HFS 3701T (pdf) Therapy Prior Approval Request Form
  - Practitioner Order
  - Therapist Initial Evaluation
  - Plan of Care

  For initial and renewal requests Fax to: (217) 524-0099
  For reviews or to submit additional info Fax to: (217) 558-4359
Revision of Form HFS 1409
Prior Approval Request

- The Department has recently reformatted the HFS 1409 Prior Approval Request Form, however there are no changes to the content of the form.

- The new version is available in a PDF-fillable format on the Medical Forms Page at:
  http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx

- The Department will no longer stock a paper version for ordering from the warehouse. Providers must print off the website version for submission.

- Please refer to the January 26, 2016 provider notice at:
  https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160126a.aspx
Recent Updates

- ACEs and CCEs have either partnered with existing MCOs, transitioned to become Managed Care Community Networks (MCCNs), or have terminated as an entity. There are no active ACE/CCEs at this time, as all transitions are now complete.

- Health Alliance Connect is leaving the Illinois Medicaid market effective December 31, 2016. Current Health Alliance members are being notified via letter of their membership ending. Meridian Health Plan will be participating in both the Integrated Care Program and Family Health Program in areas where Health Alliance will no longer serve. Individuals with Health Alliance will return to fee-for-service for a short time and be sent a new enrollment packet with their health plan choices. For more information about Health Alliance’s exit, please refer to the October 27, 2016 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn161027b.aspx

- The Managed Long Term Supports and Services (MLTSS) Program kicked off July 1, 2016. This program only covers dual eligibles in the Greater Chicago Region that have opted out of the Medicare Medicaid Alignment Initiative. To learn more about MLTSS, including how to identify an MLTSS client and what services are covered under this program, please refer to the August 31, 2016 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160831a.aspx.
Managed Care / Care Coordination (cont’d)

Managed Care Manual

- Please refer to the January 19, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160119a.aspx. A link to the Managed Care Manual is provided in the notice.

- The manual contains information regarding the Department’s Managed Care Programs

*Health plan contact information may be found in the January 4, 2016 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160104a.aspx

**Providers may contact the HFS Bureau of Managed Care at 217-524-7478 with questions or specific issues regarding the managed care plans
Publication of Public Notices on HFS Website

- Please refer to the March 18, 2016 provider notice at [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160318a.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160318a.aspx)

- The Centers for Medicare and Medicaid Services (CMS) published final rules designed to ensure that States’ fee-for-service Medicaid payments comply with the access standards outlined in Section 1902(a)(30)(A) of the Social Security Act (SSA)

- This new rule recognizes electronic publications posted on the Medicaid state agency’s web site as an acceptable form of public notice

- The Department has developed a webpage on the HFS web site for the purpose of providing public notice of proposed changes in methods and standards for setting payment rates of service. A link to the public notices can be found under the “Stay Informed” section located at the bottom left hand corner of the HFS Home Page at: [https://www.illinois.gov/hfs/Pages/default.aspx](https://www.illinois.gov/hfs/Pages/default.aspx)
Obtaining A Medical Card and Health Plan/Primary Care Provider (PCP) for Newborns

- Please refer to the May 4, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160504a.aspx
- The Department recommends that a new guide, the HFS Form 4691 How to Get a Medical Card and a Primary Care Provider (PCP) for Your Baby, be given to women receiving prenatal care. Information in the guide is relevant to all newborns whether their mothers are covered by managed care organizations or in fee-for-service.
- The guide provides links and contacts, along with clear instructions, on how to add a baby to a medical case, as well as how to choose a health plan or PCP for the baby.
- Any child born to a participant is automatically eligible for medical assistance for one (1) year as long as the mother remains eligible for assistance and the child lives with her.
- The mother is not required to submit a formal application for the child to be added to her case. Medical providers may request that a newborn be added to the Medical Assistance case by contacting the local DHS Family Community Resource Center. Local site locations can be found at: www.dhs.state.il.us.
Home Health Care Services

- The Department has reissued the Chapter R-200, Handbook for Home Health Agencies: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx
- Please refer to the May 3, 2016 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160503b.aspx regarding Home Health coding and billing changes effective January 1, 2016
- Coding Changes
  - Effective January 1, 2016 HCPCS G0154 became obsolete and was replaced with two new codes: **G0299** for direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting and **G0300** for direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting. The code for Certified Nurses Aides (CNA) remains **G0156**.
- Billing Changes:
  - Effective January 1, 2016 claims for G0299, G0300 and G0156 must be submitted for each date of service
  - The total number of service hours per date of service should be reported in the Units/Quantity field
  - The Provider Charge/Line Item Charge Amount is the approved hourly rate multiplied by the number of hours for that service
Home Health Care Service Reminders

- **Face-To-Face Requirement**
  - Dates of service beginning January 1, 2014 the Department requires that the initial certification of Home Health intermittent skilled nursing services and/or therapy services include documentation that a face-to-face encounter was conducted by the practitioner ordering the home health services.
  - Please refer to the December 11, 2013 provider notice at [https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131211a.aspx](https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131211a.aspx) for further information and details regarding the conditions that must be met during the face-to-face encounter.

- **Rate Change**
  - As a result of Senate Bill 741, the Department will increase the rates paid to Home Health Agencies for all-inclusive intermittent visits, and for In-Home shift hourly nursing services rendered by a Certified Nursing Assistant (CNA), effective July 1, 2014.
  - Please review the October 2, 2014 Informational Notice at [https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141002a.aspx](https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141002a.aspx)
Family Planning Policy Reminders

Dispensing fee for certain 340B purchased birth control methods
- Effective July 1, 2014 the dispensing fee for family planning methods purchased through the 340B federal Drug Pricing Program was increased to $35.00
- Providers must identify 340B purchased drugs by reporting modifier “UD” in conjunction with the appropriate procedure code
- The provider charge should be the actual acquisition cost plus the $35 dispensing fee

Vaginal Ring, Contraceptive Patch and Oral Contraceptives
- Providers must dispense the three (3) month supply allowable by the Department whenever possible
- Exceptions may be made when medically contraindicated and documented in the patient’s medical record
- Please ensure medical records document the reason for NOT dispensing the required three (3) month supply

Change to Procedure Code for Billing of Emergency Contraceptive Pills (ECPs)
- Please refer to the April 29, 2016 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160429a.aspx
- Effective with dates of service June 1, 2016 all ECPs must be billed using procedure code J8499 to allow proper reimbursement to providers; the Department will no longer reimburse ECPs billed with procedure code S4993
Tobacco Cessation Counseling Services

- Please refer to the August 26, 2014 provider notice at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140826a.aspx

- Counseling sessions must be provided by, or under the supervision of, a physician or any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide covered services other than tobacco cessation services

- Eligible populations and duration limits:
  - pregnant and up to 60-day post-partum women age 21 and over – limited to a maximum of three quit attempts per calendar year, up to four individual face-to-face counseling sessions per quit attempt, maximum of 12 counseling sessions (includes any combination of the two applicable procedure codes)
  - children through age 20 – no coverage limits

- Covered services:
  - 99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
  - 99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
  - Pharmacotherapy – refer to the provider notice for duration limits and prior approval requirements
Annual Medical Cards

- Please refer to the January 30, 2013 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130130a.aspx

- **Providers must verify medical eligibility at each visit or risk non-payment**

- Providers may not charge participants to verify eligibility

- If the individual provides a Medical Card, Participant Identification Number (RIN), or Social Security number and date of birth, providers may verify eligibility through one of the following resources:
  - MEDI Internet site at: http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx  
    **when using MEDI be sure to scroll down to view possible MCO enrollment**
  
  - The REV system. A list of vendors is available at: http://www.illinois.gov/hfs/MedicalProviders/rev/Pages/default.aspx
  
  - The Automated Voice Response System (AVRS) at 1-800-842-1461.
Four Prescription Policy

- HFS has reduced the number of prescriptions that can be filled in a thirty-day period, without prior authorization, to four. Information regarding this policy is posted on the web site at: http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx

- Exceptions to the prescription policy will be allowed in certain situations, with prior approval. As a reminder, effective July 1, 2014 Senate Bill 741 eliminated the prior authorization requirement anti-psychotic drugs and for children with complex medical needs enrolled in a CCE solely to coordinate their care.

- A prior approval request for exception can be initiated electronically on the MEDI system. Please refer to the September 4, 2012 informational notice entitled Drug Prior Approval/Refill Too Soon Entry System), posted on the web site at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120904a.aspx

- Effective with the December 10, 2013 provider notice at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131210a.aspx, the Department will not require prior approval or four prescription policy overrides for anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder according to Department records.
Changes to Illinois Hemophilia Program

- Effective with dates of service on or after September 1, 2012, HFS began reimbursing services provided to participants in the Illinois Hemophilia Program at the Department’s standard reimbursement rates.
- As a result, services were no longer reimbursed at the provider’s billed charges.
- The Illinois Hemophilia Program no longer offers additional coverage for primary care physician visits to qualifying participants due to cancellation of the federal waiver program.
- Effective January 1, 2014 a patient’s primary insurance may begin to cover the costs currently covered through the State Hemophilia Program. In accordance with Public Act 98-0104, patients must meet their obligations and may be required to obtain and provide proof of health coverage to the Department. Payment of a tax penalty for not obtaining insurance does not meet the requirement. The Department has notified current participants by letter regarding changes. Please refer to the December 27, 2013 provider notice at https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131227a.aspx for more information and a provider contact number.
Submittal of Claims for Multi-Use Vials

- Please reference the November 10, 2014 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141110a.aspx

- When billing the department for a multi-use vial, providers must only bill for the quantity of the drug actually dispensed

- Claims submitted for an entire vial, when a partial vial was used are subject to audit and/or recoupment of any payment made for the unused portion of the medication
Services to Hospice-Enrolled Participants

- Effective with dates of service on or after July 1, 2012, some services are no longer covered for non-hospice providers serving patients enrolled in the Department’s hospice program.

- These restrictions do not apply to Medicare recipients or participants under age 21 years.

- For details and a complete list of non-covered services please refer to the June 27, 2012 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120627a.aspx

- These restrictions do not affect services provided and billed by the hospice agency.

- **Exception**: Physician and APN services will be reimbursed only if the service is not related to the terminal illness, identified on a claim by applying the GW modifier to the procedure code.
340B Purchased Drugs

- Section 340B of the Public Health Service Act limits the cost of covered outpatient drugs to certain federal grantees, FQHC look-alikes, and qualified hospitals. These providers purchase pharmaceuticals at significantly discounted prices. Such providers enrolled with the US Department of Health and Human Resources Administration are considered 340B providers.

- Registration for the program is completed through the Office of Pharmacy Affairs, 1-800-628-6297

- Providers enrolled with HFS as a provider type other than pharmacy who are submitting fee-for-service claims for 340B purchased drugs must charge HFS no more than their actual acquisition cost for the drug product

- Dispensing Fees for 340B Purchased Drugs:
  - Effective with dates of service on or after February 1, 2013, a $12.00 dispensing fee add-on applies to generic and brand name drugs purchased through the 340B program
  - Effective July 1, 2014 the dispensing fee for family planning methods purchased through the 340B federal Drug Pricing Program was increased to $35.00

- Providers must identify 340B drugs by modifying the procedure code with the UD modifier. The charge amount must be the actual acquisition cost plus the applicable dispensing fee.

- Reimbursement for 340B purchased drugs will be the lesser of the actual acquisition for the drug, as billed by the provider, or the Department’s established 340B allowable reimbursement rate for the drug, plus the applicable dispensing fee
180 Day Time Limit for Claim Submittal

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

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

- Participants with Medicare as primary payer
- Pregnant women, including a 60-day postpartum period. *Either a primary diagnosis of pregnancy in the ICD-10 640-677 diagnosis series on the claim or current EDD (estimated due date) on the MEDI system are required.*
- All Kids Assist (HFS-covered children under 19 years of age who are not All Kids Share or All Kids Premium)
- Residents of nursing homes, ICFs for the developmentally disabled, and supportive living facilities
- Hospice patients
- All non-institutionalized individuals whose care is subsidized by DCFS or Corrections
- Participants enrolled in HFS MCOs
Services exempt from cost sharing include:

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

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

- Please refer to the June 19, 2015 provider notice at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150619b.aspx
- For dates of service July 1, 2015 and after, providers may bill the department for Medicare co-insurance and deductibles for individuals enrolled in a Medicare Advantage Plan and Medicaid
- HFS will consider cost-sharing when the participant is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits
- Providers must submit claims with the twenty-four (24) month timely filing limit for Medicare crossovers
- The Explanation of Benefits (EOB) should be reviewed to determine if the client has co-insurance and deductibles
- Non-Institutional providers are required to submit a paper HFS 3797, Medicare Crossover or 837P and institutional providers are required to submit a paper UB04 or 837I to the department
- Currently, the appropriate three digit TPL code 909 or 910 is required in conjunction with the two digit TPL Status Code. The Department is working to implement a new three digit TPL code to identify Medicare Advantage Plans. Once programmed, providers will be notified via informational notice.
Office Visits

- All E/M CPT codes require a face-to-face encounter with the physician/APN/PA. The only exception is 99211, which may be billed when a recipient comes to the office for a service, such as an injection, and the physician is not required to be present.

- When a therapeutic procedure is performed during an office visit, reimbursement will be made for whichever service the Department prices higher, either the visit or the procedure, but not for both unless it is an initial office visit.

- Diagnostic services are paid separately from a visit based on medical necessity.

- A participant may be designated as a “new patient” only once in a lifetime by an individual practitioner, partner of the practitioner or collectively in a group regardless of the number of practitioners who may eventually see the participant.
EPSDT Codes

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

- Immunizations (Vaccine billing instructions are located in Chapter 200, Appendix A-9)
  - 90476-90749
  - For information regarding HPV vaccine billing, please refer to the March 11, 2010 provider notice at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn100311a.aspx. As a reminder, the SL modifier should only be used by Certified Local Health Departments for participants age 19+.
  - As a reminder, reimbursement for the practice expense of administering injections is included in the office visit when the participant sees a practitioner. If the participant is seen solely for the injection, the CPT code for a minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician (99211) may be submitted to cover the injection service expense. This information may be found in topic A-226 of the Chapter A-200 Practitioner Handbook at https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx
EPSDT Codes (cont’d)

- Lead Screenings
  - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the specimen collection
  - if specimen is not being sent to IDPH and is being analyzed at the office bill 83655

- Developmental Screening
  - 96110

- Developmental Assessments
  - 96111

- Hearing Screening
  - 92551

- Vision Screening
  - 99173

- Labs/X-rays

- Mental Health Risk Assessment
  - 99420

Additional information may be found in the Healthy Kids Handbook (HK-200) & Appendices at: [https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/HK200.aspx](https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/HK200.aspx)
Adult Preventive Services

- Services rendered for the prevention or diagnosis of a primary disease, or the prevention complication of a chronic disease
- Covered services include preventive evaluation and management office visits, immunizations for participants 21 years and older when administered in accordance with CDC guidelines, screenings for cancer, and diagnostics test and procedures
- One adult preventive medical visit is allowed per year (333 days) in addition to 1 inter-periodic screening visit (e.g. change of PCP)

**Adult Preventive Visits**
- 99385-99387 new patients
- 99395-99397 established patients

**Immunizations**
- payable when medically necessary and administered according to CDC guidelines
- example: influenza or pneumococcal
BMI Assessment & Obesity-Related Weight Management Follow-Up for Children & Adolescents

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

- **Prenatal Services**
  - 0500F (initial prenatal visit) – date of the last menstrual period (LMP) must be reported when billing the initial prenatal CPT
  - 0502F (subsequent prenatal visit) – routine urinalysis is not separately reimbursable
  - 0503F/59430 (postpartum visit)

- **Perinatal Depression Risk Assessment**
  - H1000 (screening during a prenatal visit)
  - 99420 with HD modifier (screening during a postpartum visit)
  - Screening during the infant’s visit when the mother is not Medicaid eligible is considered a risk screening for the infant; bill 99420 with HD modifier using the infant’s RIN

- Additional information is available at:
  - [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn041130d.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn041130d.aspx)
A practitioner may charge only for an *initial* therapy treatment (prior to referral to a licensed therapist) provided in the practitioner’s office by the practitioner or the practitioner’s salaried staff under the practitioner’s direct supervision.

This may be billed in addition to the appropriate evaluation and management CPT code.

Ongoing therapy services are only reimbursed to an enrolled individual therapist.

Individual therapists and hospitals should refer to Chapter J-200, Handbook for Providers of Therapy Services at [http://www.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf](http://www.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf) and the therapy fee schedule at [http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx](http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx) for information regarding therapy services.
Provider Fee Schedules

- Provider fee schedules may be found on the Medicaid Reimbursement page at https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx

- Provider fee schedules provide information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization.

- HFS strives to update the Practitioner Fee Schedule quarterly. Other fee schedules are updated as needed.

- The most recent Practitioner Fee Schedule was posted to the website October 13, 2016 and is effective with dates of service beginning October 1, 2016.

- The Practitioner Fee Schedule should be used in conjunction with the Practitioner Fee Schedule Key, Modifier Listing, and Lab Rates as applicable.
Third Party Liability

- Medicaid is nearly always the payer of last resort. All known TPL must be billed before claims may be submitted to HFS. *Exceptions include services to women with a diagnosis of pregnancy and preventive services for children.*
  - Providers are not required to bill a participant’s private insurance carrier for antepartum care services prior to billing the Department, however practitioners must bill a participant’s private insurance carrier prior to billing the Department for deliveries.

- Client-specific TPL appears on the MEDI eligibility detail screen
- Medicare crossover claims must contain the amount paid by Medicare for each service
- When a client is identified on the HFS system as having TPL, even if the client or TPL source states the TPL is not in effect, the claim must contain complete TPL information, including:
  - **TPL resource code** - TPL Resource Code Directory currently appears in Chapter 100 Appendix 9 (note this will be posted separately from Chap 100 on the website in the near future)
  - **TPL status codes** – TPL status codes may be found in the billing instructions for paper claim preparation in the appendices of all Chapter 200 Handbooks
  - **Payment amounts**
  - **TPL date** - instructions may be found in the billing instructions for paper claim preparation in the appendices of all Chapter 200 Handbooks

**For discrepancies between TPL reported by participants and TPL information reported in MEDI please contact the TPL unit at 217-524-2490**
HFS Paper Claim Forms

- HFS 2360 – Instructions in Chapter 200, Appendix A-1
  - Physicians
  - APNs
- HFS 1443 – Instructions in the appendices of each applicable handbook
  - Chiropractors
  - Podiatrists
  - Therapists (PT, OT and Speech)
  - Audiologists
  - Optometrists
  - SASS (Children’s mental health)
- HFS 3797 – Instructions in the appendices of each applicable handbook
  - All providers billing Medicare crossovers

**Please refer to instructions in the appendices for details regarding required, conditionally required, and optional fields**
The Chapter 300 Companion Guide for 5010 may be viewed at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

5010 submissions sent by a Clearinghouse or uploaded via batch to the MEDI system will receive a 999 Functional Acknowledgement

Please note: A second 999 Functional Acknowledgment is possible as additional audit checks are completed. A second 999 always indicates rejection of the file(s).

**Providers are responsible for verifying that HFS has accepted all submitted files**
Medical Electronic Data Interchange (MEDI)

- MEDI is available for:
  - Verifying client eligibility
  - Submitting claims
  - Submitting replacement claims (bill type ‘7’) and voids (bill type ‘8’)
  - Checking claim status - *NOTE: HFS Billing Consultants do not check claim status for providers over the phone*
  - 835 Electronic Remittance Advice - available to the designated payee. *NOTE: HFS error codes are not included on the 835. Codes provided on the 835 are national reason and remark codes which can be found at: [http://www.wpc-edi.com/reference](http://www.wpc-edi.com/reference). Providers must refer to the paper remittance advice for additional information regarding claim rejections.*

- Login and access requires a State of Illinois Digital Identity

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

- There are two types of USER registrations in the MEDI System:
  - Administrator (required - limit of 2)
  - Employees (no limit)
Once the Illinois Digital Identity registration is complete, login to: http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx

For technical assistance with the following please contact 217-524-3814:
- Authentication error (non-password)
- Upload batch
- 835 (ERA) and 999 (FA) assistance

For technical assistance with the following please contact 1-800-366-8768, option 1, option 2:
- registration
- digital certificate/password reset
- administrator/biller authorization
Voids & Replacement Claims

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

- **Replacement Claims**
  - completed electronically by using bill type ‘7’ to void a single service line or entire claim

- The instructions for electronic voids and replacement claims may be found in the Chapter 300 Companion Guide at: [http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx](http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx)

- **Note**: voids and replacement claims require the 17-digit DCN from the original, paid claim. Using the 12-digit DCN from the paper remit:
  - Add ‘201’ to the beginning of that 12-digit number
  - Add *either* the 2-digit section number to void or replace a single service line, or ‘00’ to void or replace an entire claim, to the end of that 12-digit number
Reminders Regarding Medical Billing Industry Standards

- HFS is required to enforce the National Correct Coding Initiative (NCCI) edits that Medicare has used for several years. HFS continues to review updates to these edits as they are published and implement payment policy changes accordingly.

- The conversion from ICD-9-CM code set to ICD-10-CM code set as federally mandated was effective October 1, 2015. ICD-9-CM diagnosis codes will no longer be accepted on electronic and paper claims with service dates on or after October 1, 2015, and HFS will reject claims that are billed with both ICD-9-CM and ICD-10-CM diagnosis codes on the same claim.

- In the future, referring/ordering and prescribing practitioners will be required to be enrolled with Medicaid. Providers will be notified via provider notice prior to implementation.
COMMON BILLING ERRORS

- C02 – additional information required
- C03 – illogical quantity
- C17 – place of service illogical
- D01 – duplicate claim – previously paid (will include payment voucher number)
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 – client in MCO – Integrated care program
- G55 – submitted later than 180 days, but not more than one year, from date of service
- H50 – payee not valid for provider
- H55 – rendering NPI missing/invalid
- M93 – missing payee/multiple payees
- R36 – client has Medicare – bill Medicare first
- T21 -- Client has Third Party Liability

For HFS proprietary error code explanations, please refer to the Error Codes (xls) link at the bottom of the Provider Handbooks page at https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx
How To Contact HFS

Main Number: 877-782-5565

Option ‘1’ for English or ‘2’ for Spanish
Option ‘1’ for recipient or ‘2’ for provider

- IMPACT: option 1
- Recipient Eligibility: option 2
- Prior Approval: option 3
- For Billing Issues: option 4
  - Hospital: option 1
  - Audiology & DME: option 2
  - Dental: option 3
  - Transportation: option 4
  - Optical: option 5
  - Pharmacy: option 6
  - LEA, Home Health, Therapies: option 7
  - Community Mental Health: option 8
  - Physicians and all other: option 9
- Electronic Health Records: option 5

**Please Note**: Claim status is NOT available by phone. Claim status is available using MEDI, the 835 ERA, and the paper remittance advice.
Resources

- HFS home page: http://www.illinois.gov/hfs/Pages/default.aspx
- Handbooks, including appendices:
  http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx
  - Chapter 100 – General Policy and Procedures
  - Chapter 200 – Practitioner Handbook
  - Chapter 300 – Handbook for Electronic Processing
  - Chapter HK-200 – Handbook for Providers of Healthy Kids Services
- Provider Releases and E-Mail Notification for Releases:
  http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx
Questions